AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Estimate Package

2012-13 MAY REVISION

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

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	2011-12 in 2012-13 May Revision					2011-12 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	**$486,625**	**$74,064**	**$118,797**	**$4,756**	**$289,008**	**$511,148**	**$74,064**	**$100,632**	**$82,625**	**$253,827**	**($24,522)**		**$18,165**	**($77,869)**	**$35,182**
ADAP Expenditure Estimate	$480,144	$74,064	$118,797	$4,651	$282,632	$503,620	$74,064	$100,632	$82,625	$246,299	($23,476)	$	$18,165	($77,974)	$36,333
Prescription Costs	$472,942	$72,953	$117,015	$4,581	$278,392	$496,526	$73,036	$99,235	$81,479	$242,776	($23,584)	($83)	$17,780	($76,898)	$35,617
Basic Prescripton Costs	$477,578	$72,953	$117,015	$4,581	$283,029	$522,930	$73,036	$99,235	$81,479	$269,180	($45,352)	($83)	$17,780	($76,898)	$13,849
Non-Legacy LIHP Expenditure Impact	($685)				($685)						($685)				($685)
Legacy LIHP Expenditure Impact	($2,017)				($2,017)						($2,017)				($2,017)
OA-PCIP Expenditure Impact	($541)				($541)	($9,945)				($9,945)	$9,404				$9,404
OA-HIPP Expenditure Impact	($1,393)				($1,393)	($6,410)				($6,410)	$5,017				$5,017
PBM Contract: Pharmacy Split Savings*						($1,336)				($1,336)	$1,336				$1,336
PBM Contract: Change in Reimburse. Rate*						($1,901)				($1,901)	$1,901				$1,901
True-Out-Of-Pocket Costs (HCR)*						($6,812)				($6,812)	$6,812				$6,812
PBM Operational Costs	$7,202	$1,111	$1,782	$70	$4,239	$7,094	$1,028	$1,397	$1,146	$3,523	$108	$83	$385	($1,077)	$717
Basic PBM Costs	$7,213	$1,111	$1,782	$70	$4,250	$15,209	$2,204	$2,995	$2,458	$7,553	($7,997)	($1,093)	($1,213)	($2,388)	($3,303)
Non-Legacy LIHP PBM Costs	($10)				($10)						($10)				($10)
Legacy LIHP PBM Costs	$29				$29						$29				$29
OA-PCIP PBM Costs	($8)				($8)						($8)				($8)
OA-HIPP PBM Costs	($21)				($21)						($21)				($21)
PBM Contract: Change in Transaction Fees**						($8,115)	($1,176)	($1,598)	($1,311)	($4,030)	$8,115	$1,176	$1,598	$1,311	$4,030
LHJ Administration	$1,000				$1,000	$1,000				$1,000					
Insurance Assistance Program: Medicare Part D	$1,000				$1,000	$1,000				$1,000					
Insurance Assistance Program: OA-PCIP	$264				$264	$2,376				$2,376	($2,112)				($2,112)
Insurance Assistance Program: OA-HIPP	$4,218		$1,700	$105	$4,113	$3,019		$1,700		$3,019	$1,199			$105	$1,093
Tropism Assay						$133				$133	($133)				($133)
Support/Administration Funding	$2,570		$1,178	$411	$981	$2,586		$1,178	$411	$997	($16)				($16)

Table 1b: Expenditure Comparison: FY 2011-12 in *2012-13 May Revision* to FY 2011-12 in *2012-13 Governor's Budget* (*November Estimate)* (000's)

	2011-12 in 2012-13 May Revision					2011-12 in 2012-13 Governor's Budget (November Estimate)					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	**$486,625**	**$74,064**	**$118,797**	**$4,756**	**$289,008**	**$481,830**	**$74,064**	**$118,797**	**$5,785**	**$283,184**	**$4,795**			**($1,029)**	**$5,825**
ADAP Expenditure Estimate	$480,144	$74,064	$118,797	$4,651	$282,632	$477,304	$74,064	$118,797	$4,933	$279,510	$2,840			($282)	$3,122
Prescription Costs	$472,942	$72,953	$117,015	$4,581	$278,392	$470,144	$72,953	$117,015	$4,859	$275,317	$2,797			($278)	$3,075
Basic Prescripton Costs	$477,578	$72,953	$117,015	$4,581	$283,029	$506,649	$72,953	$117,015	$4,859	$311,822	($29,071)			($278)	($28,793)
Non-Legacy LIHP Expenditure Impact	($685)				($685)						($685)				($685)
Legacy LIHP Expenditure Impact	($2,017)				($2,017)	($19,604)				($19,604)	$17,588				$17,588
OA-PCIP Expenditure Impact	($541)				($541)	($2,806)				($2,806)	$2,265				$2,265
OA-HIPP Expenditure Impact	($1,393)				($1,393)	($4,060)				($4,060)	$2,667				$2,667
PBM Contract: Pharmacy Split Savings*						($1,293)				($1,293)	$1,293				$1,293
PBM Contract: Change in Reimburse. Rate*						($2,300)				($2,300)	$2,300				$2,300
True-Out-Of-Pocket Costs (HCR)*						($6,440)				($6,440)	$6,440				$6,440
PBM Operational Costs	$7,202	$1,111	$1,782	$70	$4,239	$7,160	$1,111	$1,782	$74	$4,193	$43			($4)	$47
Basic PBM Costs	$7,213	$1,111	$1,782	$70	$4,250	$7,563	$1,111	$1,782	$74	$4,596	($350)			($4)	($346)
Non-Legacy LIHP PBM Costs	($10)				($10)						($10)				($10)
Legacy LIHP PBM Costs	$29				$29	($299)				($299)	$328				$328
OA-PCIP PBM Costs	($8)				($8)	($43)				($43)	$34				$34
OA-HIPP PBM Costs	($21)				($21)	($62)				($62)	$41				$41
PBM Contract: Change in Transaction Fees**															
LHJ Administration	$1,000				$1,000	$1,000				$1,000					
Insurance Assistance Program: Medicare Part D	$1,000				$1,000	$1,000				$1,000					
Insurance Assistance Program: OA-PCIP	$264				$264	$556				$556	($293)				($293)
Insurance Assistance Program: OA-HIPP	$4,218		$1,700	$105	$4,113	$1,970		$1,700	$852	$1,118	$2,248			($747)	$2,995
Tropism Assay															
Support/Administration Funding	$2,570		$1,178	$411	$981	$2,570		$1,178	$411	$981					

* Due to a change in methodology (RMA 7) this item is incorporated into the Basic Prescription Costs line item for the *May Revision* .
**Due to a change in methodology, this item has been incorporated into the Basic PBM Costs line item.

Table 1c: Expenditure Comparison: *2012-13 May Revision* to FY 2011-12 in *2012-13 May Revision* (000's)

	2012-13 May Revision					2011-12 in 2012-13 May Revision					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	**$437,715**	**$17,150**	**$113,605**	**$6,204**	**$300,756**	**$486,625**	**$74,064**	**$118,797**	**$4,756**	**$289,008**	**($48,911)**	**($56,914)**	**($5,192)**	**$1,448**	**$11,747**
ADAP Expenditure Estimate	$427,094	$17,150	$113,605	$5,314	$291,026	$480,144	$74,064	$118,797	$4,651	$282,632	($53,049)	($56,914)	($5,192)	$663	$8,394
Prescription Costs	$420,688	$16,893	$111,901	$5,234	$286,660	$472,942	$72,953	$117,015	$4,581	$278,392	($52,254)	($56,060)	($5,114)	$653	$8,268
Basic Prescripton Costs	$547,116	$16,893	$111,901	$17,266	$401,056	$477,578	$72,953	$117,015	$4,581	$283,029	$69,538	($56,060)	($5,114)	$12,686	$118,027
Non-Legacy LIHP Expenditure Impact	($24,586)				($24,586)	($685)				($685)	($23,901)				($23,901)
Legacy LIHP Expenditure Impact	($74,770)				($74,770)	($2,017)				($2,017)	($72,753)				($72,753)
OA-PCIP Expenditure Impact	($5,738)				($5,738)	($541)				($541)	($5,197)				($5,197)
OA-HIPP Expenditure Impact	($9,302)				($9,302)	($1,393)				($1,393)	($7,909)				($7,909)
PBM Contract: Pharmacy Split Savings*															
PBM Contract: Change in Reimburse. Rate*															
True-Out-Of-Pocket Costs (HCR)*															
Client Cost Sharing	($12,033)			($12,033)							($12,033)			($12,033)	
PBM Operational Costs	$6,406	$257	$1,704	$80	$4,365	$7,202	$1,111	$1,782	$70	$4,239	($796)	($854)	($78)	$10	$126
Basic PBM Costs	$6,787	$257	$1,704	($1,281)	$6,107	$7,213	$1,111	$1,782	$70	$4,250	($425)	($854)	($78)	($1,351)	$1,857
Non-Legacy LIHP PBM Costs	($374)				($374)	($10)				($10)	($364)				($364)
Legacy LIHP PBM Costs	($1,139)				($1,139)	$29				$29	($1,168)				($1,168)
OA-PCIP PBM Costs	($87)				($87)	($8)				($8)	($79)				($79)
OA-HIPP PBM Costs	($142)				($142)	($21)				($21)	($120)				($120)
PBM Contract: Change in Transaction Fees**															
Client Cost Sharing	$1,361			$1,361							$1,361			$1,361	
LHJ Administration	$2,000				$2,000	$1,000				$1,000	$1,000				$1,000
Insurance Assistance Program: Medicare Part D	$1,000				$1,000	$1,000				$1,000					
Insurance Assistance Program: OA-PCIP	$1,186				$1,186	$264				$264	$922				$922
Insurance Assistance Program: OA-HIPP	$6,435		$1,700	$890	$5,544	$4,218		$1,700	$105	$4,113	$2,217			$785	$1,431
Tropism Assay															
Support/Administration Funding	$2,501		$1,178	$411	$912	$2,570		$1,178	$411	$981	($69)		$		($69)

Table 1d: Expenditure Comparison: *2012-13 May Revision* to *2012-13 Governor's Budget (November Estimate)* (000's)

	2012-13 May Revision					2012-13 Governor's Budget					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	**$437,715**	**$17,150**	**$113,605**	**$6,204**	**$300,756**	**$403,837**	**$49,300**	**$102,572**	**$6,445**	**$245,520**	**$33,877**	**($32,150)**	**$11,033**	**($241)**	**$55,236**
ADAP Expenditure Estimate	$427,094	$17,150	$113,605	$5,314	$291,026	$395,073	$49,300	$102,572	$5,556	$237,644	$32,022	($32,150)	$11,033	($243)	$53,382
Prescription Costs	$420,688	$16,893	$111,901	$5,234	$286,660	$389,147	$48,561	$101,034	$5,473	$234,079	$31,541	($31,668)	$10,867	($239)	$52,581
Basic Prescripton Costs	$547,116	$16,893	$111,901	$17,266	$401,056	$572,898	$48,561	$101,034	$21,959	$401,345	($25,782)	($31,668)	$10,867	($4,692)	($289)
Non-Legacy LIHP Expenditure Impact	($24,586)				($24,586)						($24,586)				($24,586)
Legacy LIHP Expenditure Impact	($74,770)				($74,770)	($137,805)				($137,805)	$63,035				$63,035
OA-PCIP Expenditure Impact	($5,738)				($5,738)	($9,809)				($9,809)	$4,071				$4,071
OA-HIPP Expenditure Impact	($9,302)				($9,302)	($8,350)				($8,350)	($952)				($952)
PBM Contract: Pharmacy Split Savings*						($1,457)				($1,457)	$1,457				$1,457
PBM Contract: Change in Reimburse. Rate*						($2,591)				($2,591)	$2,591				$2,591
True-Out-Of-Pocket Costs (HCR)*						($7,254)				($7,254)	$7,254				$7,254
Client Cost Sharing	($12,033)			($12,033)		($16,486)			($16,486)		$4,453			$4,453	
PBM Operational Costs	$6,406	$257	$1,704	$80	$4,365	$5,926	$740	$1,539	$83	$3,565	$480	($482)	$165	($4)	$801
Basic PBM Costs	$6,787	$257	$1,704	($1,281)	$6,107	$6,301	$740	$1,539	($1,917)	$5,940	$486	($482)	$165	$635	$168
Non-Legacy LIHP PBM Costs	($374)				($374)						($374)				($374)
Legacy LIHP PBM Costs	($1,139)				($1,139)	($2,099)				($2,099)	$960				$960
OA-PCIP PBM Costs	($87)				($87)	($149)				($149)	$62				$62
OA-HIPP PBM Costs	($142)				($142)	($127)				($127)	($14)				($14)
PBM Contract: Change in Transaction Fees**															
Client Cost Sharing	$1,361			$1,361		$2,000			$2,000		($639)			($639)	
LHJ Administration	$2,000				$2,000	$2,000				$2,000					
Insurance Assistance Program: Medicare Part D	$1,000				$1,000	$1,000				$1,000					
Insurance Assistance Program: OA-PCIP	$1,186				$1,186	$1,852				$1,852	($666)				($666)
Insurance Assistance Program: OA-HIPP	$6,435		$1,700	$890	$5,544	$3,913		$1,700	$889	$3,024	$2,522			$1	$2,521
Tropism Assay															
Support/Administration Funding	$2,501		$1,178	$411	$912	$2,501		$1,178	$411	$912	$		$		

* Due to a change in methodology (RMA 7) this item is incoporated into the Basic Prescription Costs line item for the *May Revision*.
** Due to a change in methodology, this item is fully incorporated into the Basic PBM Costs line item.

TABLE 2a: Resource Comparison: FY 2011-12 in *2012-13 May Revision* to 2011-12 Budget Act (000's)

	2011-12 in 2012-13 May Revision					2011-12 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	**$463,479**	**$74,064**	**$119,975**	**$5,167**	**$264,273**	**$514,745**	**$74,064**	**$101,810**	**$83,036**	**$255,835**	**($51,266)**		**$18,165**	**($77,869)**	**$8,438**
Basic Rebate Revenues	$250,639				$250,639	$230,444				$230,444	$20,195				$20,195
Income from Surplus Money Investments	$120				$120	$300				$300	($180)				($180)
Federal Funds	$103,750		$103,750			$98,810		$98,810			$4,940		$4,940		
General Funds	$5,167			$5,167		$83,036			$83,036		($77,869)			($77,869)	
OA-PCIP Revenue impact	($106)				($106)	($1,834)				($1,834)	$1,728				$1,728
OA-HIPP Revenue impact	($20)				($20)	$309				$309	($329)				($329)
Renegotiated Sup. Rebate/Price Freeze Agreements	$13,640				$13,640	$26,616				$26,616	($12,976)				($12,976)
One-Time Increase in Federal Funds*	$16,225		$16,225			$3,000		$3,000			$13,225		$13,225		
Safety Net Care Pool Funds	$74,064	$74,064				$74,064	$74,064								

TABLE 2b: Resource Comparison: FY 2011-12 in *2012-13 May Revision* to FY 2011-12 in *2012-13 Governor's Budget* (*November Estimate)* (000's)

	2011-12 in 2012-13 May Revision					2011-12 in 2012-13 Governor's Budget					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	**$463,479**	**$74,064**	**$119,975**	**$5,167**	**$264,273**	**$447,418**	**$74,064**	**$119,975**	**$5,344**	**$248,035**	**$16,061**			**($177)**	**$16,238**
Basic Rebate Revenues	$250,639				$250,639	$237,256				$237,256	$13,382				$13,382
Income from Surplus Money Investments	$120				$120	$120				$120					
Federal Funds	$103,750		$103,750			$103,750		$103,750							
General Funds	$5,167			$5,167		$5,344			$5,344		($177)			($177)	
OA-PCIP Revenue impact	($106)				($106)	($508)				($508)	$403				$403
OA-HIPP Revenue impact	($20)				($20)	$48				$48	($68)				($68)
Renegotiated Sup. Rebate/Price Freeze Agreements	$13,640				$13,640	$11,119				$11,119	$2,521				$2,521
One-Time Increase in Federal Funds*	$16,225		$16,225			$16,225		$16,225							
Safety Net Care Pool Funds	$74,064	$74,064				$74,064	$74,064								

***Includes: 2011 ADAP Supplemental Award, RW Part B Supplemental Award, ADAP Emergency Relief Funding and 2010 carryover funding.**

TABLE 2c: Resource Comparison: *2012-13 May Revision* to FY 2011-12 in *2012-13 May Revision* (000's)

	2012-2013 May Revision					2011-12 in 2012-13 May Revision					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	**$423,191**	**$17,150**	**$114,783**	**$6,615**	**$284,643**	**$463,479**	**$74,064**	**$119,975**	**$5,167**	**$264,273**	**($40,288)**	**($56,914)**	**($5,192)**	**$1,448**	**$20,370**
Basic Rebate Revenues	$267,203				$267,203	$250,639				$250,639	$16,564				$16,564
Income from Surplus Money Investments	$120				$120	$120				$120	$				
Federal Funds	$106,357		$106,357			$103,750		$103,750			$2,607		$2,607		
General Funds	$6,615			$6,615		$5,167			$5,167		$1,448			$1,448	
Non-Legacy LIHP Expenditure Impact	($4,082)				($4,082)						($4,082)				($4,082)
Legacy LIHP Expenditure Impact	($9,199)				($9,199)						($9,199)				($9,199)
OA-PCIP Revenue impact	($1,202)				($1,202)	($106)				($106)	($1,097)				($1,097)
OA-HIPP Revenue impact	($261)				($261)	($20)				($20)	($241)				($241)
Renegotiated Sup. Rebate/Price Freeze Agreements	$32,064				$32,064	$13,640				$13,640	$18,424				$18,424
One-Time Increase in Federal Funds*	$8,426		$8,426			$16,225		$16,225			($7,799)		($7,799)		
Safety Net Care Pool Funds	$17,150	$17,150				$74,064	$74,064				($56,914)	($56,914)			

TABLE 2d: Resource Comparison: *2012-13 May Revision* to *2012-13 Governor's Budget* (*November Estimate*) (000's)

	2012-13 May Revision					2012-13 Governor's Budget					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund	**Total**	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	**$423,191**	**$17,150**	**$114,783**	**$6,615**	**$284,643**	**$396,012**	**$49,300**	**$103,750**	**$5,967**	**$236,995**	**$27,179**	**($32,150)**	**$11,033**	**$648**	**$47,648**
Basic Rebate Revenues	$267,203				$267,203	$257,298				$257,298	$9,905				$9,905
Income from Surplus Money Investments	$120				$120	$120				$120					
Federal Funds	$106,357		$106,357			$103,750		$103,750			$2,607		$2,607		
General Funds	$6,615			$6,615		$5,967			$5,967		$648			$648	
Non-Legacy LIHP Expenditure Impact	($4,082)				($4,082)						($4,082)				($4,082)
Legacy LIHP Expenditure Impact	($9,199)				($9,199)	($33,078)				($33,078)	$23,879				$23,879
OA-PCIP Revenue impact	($1,202)				($1,202)	($3,535)				($3,535)	$2,332				$2,332
OA-HIPP Revenue impact	($261)				($261)	$108				$108	($369)				($369)
Renegotiated Sup. Rebate/Price Freeze Agreements	$32,064				$32,064	$16,081				$16,081	$15,983				$15,983
One-Time Increase in Federal Funds*	$8,426		$8,426								$8,426		$8,426		
Safety Net Care Pool Funds	$17,150	$17,150				$49,300	$49,300				($32,150)	($32,150)			

***FY 2012-13 includes 2012 ADAP Supplemental Award. FY 2011-12 includes 2011 ADAP Supplemental Award, RW Part B Supplemental Award, ADAP Emergency Relief Funding and 2010 carryover funding.**

2. MAJOR ASSUMPTIONS

Estimate Methodology

Unadjusted expenditure estimates for the *2012-13 May Revision* were derived from a linear regression model similar to that used in the *2012-13 Governor's Budget*. The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) conducted two pre-regression adjustments of the data: 1) the elimination of jails effective July 1, 2010; and 2) ADAP's Pharmacy Benefit Manager (PBM) transaction fees to account for the revised PBM fee structure effective July 1, 2011. The 36-month data set for the *2012-13 May Revision* used actual data from April 2009 through February 2012 and estimated March 2012 data, whereas the 36-month data set for the *2012-13 Governor's Budget* used data from August 2008 through July 2011.

The unadjusted revenue data set (April 2008 through March 2011 for the *2012-13 Governor's Budget* and July 2008 through June 2011 for the *2012-13 May Revision* data set) was used to estimate the revenue percent, which was applied to the revised, adjusted expenditure estimate for current and budget years.

For purposes of the *2012-13 May Revision*, expenditure and revenue adjustments were made to the Fund Condition Statement (FCS) (**Table 23**, page 35) to reflect the estimated impact of <u>two New, seven Revised, and four Continuing Assumptions (assumptions unchanged but fiscal outcome impacted by the revised expenditure estimate)</u>, including:

<u>New Major Assumptions (NMA)</u>
1. Impact of the "Non-Legacy" Low Income Health Program (LIHP) Counties on ADAP.
2. Additional 2012 Ryan White (RW) Federal Grant Funds.

<u>Revised Major Assumptions (RMA)</u>
1. Impact of the Ten "Legacy" LIHP Counties on ADAP.
2. Delayed OA-Pre-Existing Condition Insurance Plan (PCIP) Implementation.
3. Institution of a New Client Cost-Sharing Policy.
4. Increase Rebate Percentage.
5. Renegotiated Supplemental Rebate/Price Freeze Agreements.
6. Reimbursement of Federal Funding through the Safety Net Care Pool for FY 2012-13.
7. Change in Methodology: Adjust Linear Regression Expenditure Methodology.

<u>Continuing Assumptions (CA)</u>
1. Reduced PCIP Premiums.
2. OA-PCIP/LIHP Issue: Reductions in OA-PCIP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision.
3. OA-(Health Insurance Premium Payment (HIPP)/LIHP Issue: Reductions in OA-HIPP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision.

4. OA-HIPP/Medi-Cal General Fund (GF) Issue: Using GF to Pay OA-HIPP Premiums and ADAP Drug Deductibles and Co-Pays for Clients Co-Enrolled in Medi-Cal with a Share of Cost (SOC).

The remaining Major Assumptions from the *2012-13 Governor's Budget* were unchanged and did not have any updated fiscal impact:

Unchanged Assumptions without New Fiscal Impact
1. Federal Funding Issue #1: Additional 2011 Ryan White Federal Grant Funds.
2. Special Fund (SF) Funding Issue: $1 million Additional SF Budget Authority.
3. Miscellaneous Issue #1: Interest Earned Revised Down.
4. Miscellaneous Issue #2: Elimination of $132,623 for Tropism Assay Testing.

Assumption driven adjustments were added to or subtracted from the initial, unadjusted fiscal years (FYs) 2011-12 and 2012-13 expenditure and revenue estimates, respectively, to arrive at the final adjusted expenditure and revenue estimates.

New Major Assumptions

NMA 1. Impact of full implementation of the "Non-Legacy" LIHP County Programs on ADAP

California was granted a Medicaid 1115 Waiver that allows counties to receive federal funds to support LIHPs administered through the California Department of Health Care Services (DHCS). LIHPs will phase in health coverage for adults ages 19-64 years with incomes up to 200 percent of the Federal Poverty Level (FPL), as determined by each county, who are not otherwise eligible for Medicaid. While LIHP is a voluntary program at the county level, it is anticipated that most of the counties will implement LIHPs and of those participating, most have proposed implementation dates during FY 2011-12. The first counties to implement LIHP are the ten who participated in the LIHP demonstration and are called "Legacy LIHPs." To the extent that the remaining counties (Non-Legacy LIHPs) implement LIHP during FYs 2011-12 and 2012-13, there will be a fiscal impact to ADAP. OA is working closely with county representatives, DHCS LIHP staff, federal representatives, OA's PBM, advocates, and other stakeholders to clarify the complex issues and develop an integrated plan for transitioning eligible RW clients to LIHPs in the Non-Legacy counties.

LIHP consists of two optional components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). Eligible individuals must be between 19 and 64 years of age, may not be otherwise eligible for Medicaid, must be non-pregnant, must meet income eligibility standards of the respective county, must meet the county residency requirement and must be legally residing in the United States. An immigrant must meet the federal definition of a "Qualified Alien" and have a date of entry into the United States of at least five years prior to their enrollment into LIHP. Immigrants with less than five years since entry may be exempt from this

requirement if they meet one or more of the exemption criteria as established by DHCS. In addition:

- MCE – Individuals must have family incomes at or below 133 percent of FPL (based on participating county standards). MCE is not subject to a cap on federal funding and has a broader range of services than that of HCCI. Each county can set the FPL anywhere below 133 percent. An individual with private insurance or Medicare is eligible for MCE as long as the family income meets the county's FPL requirement.

- HCCI – Individuals must have family incomes from 134–200 percent of FPL, and not have third-party coverage. HCCI offers a narrower range of services than MCE and is subject to a cap on federal funding. Each county can set their FPL between 134 percent and 200 percent. The county must have an MCE program in place with an FPL of 133 percent in order to be eligible for having an HCCI. Individuals with private insurance or Medicare are not eligible for HCCI.

Transitioning ADAP clients to LIHP in the Non-Legacy counties will result in reduced ADAP expenditures and reduced rebate revenue. OA estimated total net savings of **$695,548** in FY 2011-12 and **$20,878,059** in FY 2012-13. In addition, OA estimated that 376 clients will shift from ADAP to LIHP in FY 2011-12, and an additional 1,991 clients will shift in FY 2012-13. These impact estimates are contingent upon many issues noted throughout this **NMA 1** and subject to revision in future budget processes.

Estimate Methodology

To assess the impact of LIHP on ADAP for the Non-Legacy counties, OA used the same basic methodology presented in the *2012-13 Governor's Budget* to assess the impact of LIHP on ADAP for the ten Legacy counties. However, for this **NMA 1**, OA made several adjustments to the Legacy county methodology based upon updated ADAP and LIHP implementation information. These changes will also be applied to the estimation process for the Legacy counties in **RMA 1**. The methodology changes include the following: 1) adding ADAP Medicare clients as potentially LIHP-eligible in addition to the ADAP-only and private insurance clients; 2) using current FY 2010-11 data instead of Calendar Year (CY) 2010 data as a basis for estimating the impact of LIHP on ADAP; 3) using the current 2012 FPLs instead of the 2011 FPL to determine client eligibility for LIHP; and 4) taking into account the approximate 90-day delay between when ADAP clients are screened for LIHP and the start of ADAP savings, to account for the time it takes for ADAP LIHP-eligible clients to apply to and be enrolled in LIHP. These revisions are incorporated into and further explained in the body of this **NMA 1**.

As with the implementation of LIHP in the Legacy counties, many uncertainties currently surround LIHP implementation in the Non-Legacy counties, including the following: 1) the actual implementation dates for all of the Non-Legacy LIHPs; 2) when the RW programs within these counties will begin screening their clients for LIHP; 3) what

income levels each county will select for LIHP eligibility; 4) the impact of LIHP enrollment caps and waiting lists on RW clients and thus, how many ADAP clients will transition to LIHPs; 5) the impact of LIHP charging its clients medication co-pays; 6) the impact of ADAP retroactively billing LIHPs for expenditures incurred by ADAP LIHP-eligible clients between the date of LIHP enrollment determination back to the retroactive eligibility start date as determined by the county; and 7) the impact of ADAP moving from a 12-month to a 6-month recertification period.

In future budget processes, OA may need to revise its methodology and its impact calculations based upon these uncertainties.

Eligibility Characteristics

ADAP clients included in this estimate are legal U.S. residents, between the ages of 19 and 64, and meet county-specific LIHP income eligibility characteristics, including the specific FPL requirements for the MCE and HCCI programs mentioned in the introduction to this **NMA 1**. ADAP data used in this estimate methodology included data from clients who had ADAP-only, Medicare or private insurance transactions. ADAP-only transactions are incurred by clients who have no other payment sources, and thus are dependent upon ADAP for coverage of all of their drug costs. Private insurance and Medicare transactions are incurred by ADAP clients who have private insurance or Medicare coverage for their drug costs, but for whom ADAP pays their drug deductibles and co-pays. Both the MCE and HCCI programs provide coverage for ADAP-only clients. While the MCE program provides coverage for ADAP private insurance and Medicare clients, the HCCI program does not. Therefore, OA only included transactions for ADAP private insurance and Medicare clients who qualify for the MCE program. ADAP clients who meet all of these standards are hereinafter called "potentially LIHP-eligible clients."

At the time of the *2012-13 Governor's Budget*, OA was unaware that Medicare clients were potentially eligible for LIHP; however, per subsequent guidance from the Health Resources and Services Administration (HRSA), ADAP must screen potentially MCE-eligible ADAP clients who have Medicare coverage.

Unadjusted Estimate Methodology

To calculate the unadjusted estimated future impact on ADAP due to the implementation of LIHP in the Non-Legacy counties, OA: 1) analyzed ADAP data from FY 2010-11, the latest year containing complete client, expenditure, and rebate information; 2) estimated ADAP's hypothetical client shift, reduced expenditures, and reduced rebate revenue had LIHP been in place during that FY; 3) calculated the percent of reduced expenditures and rebate revenue to overall expenditures for that FY, as well as clients shifted to clients served; and 4) applied these impact percentages to predicted client and expenditure data to estimate the impact of LIHP implementation. The specific methodology used to determine the unadjusted impacts of LIHP on ADAP for FYs 2011-12 and 2012-13 involved the following three steps:

a) OA used LIHP eligibility and implementation information provided by each Non-Legacy county along with ADAP FY 2010-11 client and expenditure data to estimate the following for each Non-Legacy county: 1) how many LIHP-eligible clients would have shifted from ADAP into LIHP had LIHP been in place in FY 2010-11; 2) how much ADAP expenditures would have been reduced in FY 2010-11 if LIHP had been in place; 3) how much ADAP rebate revenue would have been reduced in FY 2010-11; and 4) the net savings that would have been realized by ADAP in FY 2010-11 (net savings equals expenditure reductions minus rebate revenue loss).

In the *2012-13 Governor's Budget*, OA used CY 2010 expenditure, rebate, and client information because it was the most updated information available at the time and because CY 2010 data was used in a county-by-county cost analysis provided to the counties to help them evaluate their level of participation in LIHP. However, to more accurately assess the potential impacts of LIHP on ADAP, for this *2012-13 May Revision*, OA used FY 2010-11 expenditure, rebate, and client information.

LIHP FPL coverage levels were based upon the most current FPL eligibility levels provided by the Non-Legacy counties. **Table 3** lists the FPL percent levels for each program in each of the Non-Legacy counties as of March 7, 2012. At this time, none of the Non-Legacy counties are offering the HCCI program as a part of their LIHP coverage.

TABLE 3: LIHP FPL PERCENT ELIGIBILITY FOR THE NON-LEGACY COUNTIES

Non-Legacy County	MCE FPL%
CMSP* Counties	100%
Merced	100%
Monterey	100%
Pasadena (Los Angeles County)	133%
Placer	100%
Riverside	133%
Sacramento	67%
San Bernardino	100%
San Joaquin	80%
San Luis Obispo	35%
Santa Barbara	100%
Santa Cruz	100%
Stanislaus	50%
Tulare	100%
Yolo	100%

*California Medical Services Program (CMSP)

The County Medical Services Program (CMSP) is a conglomerate of 34 participating counties which are jointly implementing LIHP. The following counties are a part of CMSP: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, and Yuba. In addition, Yolo County plans on joining CMSP, but has not done so yet. Therefore, Yolo's LIHP impacts have been calculated separately from CMSP.

While Pasadena is merging with Los Angeles County's LIHP, OA calculated its LIHP impacts separately in this **NMA 1** because Pasadena was not included with Los Angeles County impacts calculated in the *2012-13 Governor's Budget*. As of March 7, 2012, Fresno is the only California county not planning on implementing LIHP.

In the *2012-13 Governor's Budget*, OA used the then-current 2011 Poverty Guidelines published by the U.S. Department of Health and Human Services (DHHS) to assess the CY 2010 impacts of LIHP on ADAP. However, DHHS has issued its 2012 Poverty Guidelines, which OA used to assess more accurately the FY 2010-11 impacts of LIHP on ADAP.

Counties have the option, with prior notice, of changing their program FPL eligibility requirements. If any such changes occur, then the impact of LIHP on ADAP will need to be adjusted.

Table 4 (next page) shows the FY 2010-11 unadjusted estimated client shift, expenditure, and rebate reductions, and net savings in the Non-Legacy counties based upon the FPL eligibility levels listed in **Table 3** (previous page).

TABLE 4: ESTIMATED UNADJUSTED IMPACTS OF LIHP ON ADAP IN THE NON-LEGACY COUNTIES FOR FISCAL YEAR 2010-11				
Non-Legacy County	**Client Shift**	**Reduced Expenditures**	**Reduced Rebate Revenue**	**Net Savings**
CMSP Counties	385	$5,404,278	$2,719,297	$2,684,981
Merced	13	$111,926	$42,715	$69,211
Monterey	47	$551,012	$418,836	$132,176
Pasadena (Los Angeles County)	124	$1,913,179	$872,156	$1,041,023
Placer	9	$112,022	$46,663	$65,359
Riverside	652	$9,171,353	$4,601,057	$4,570,295
Sacramento	391	$4,387,722	$2,039,768	$2,347,955
San Bernardino	270	$3,999,301	$1,581,872	$2,417,430
San Joaquin	95	$1,022,299	$375,549	$646,750
San Luis Obispo	16	$188,650	$98,838	$89,812
Santa Barbara	40	$416,186	$201,493	$214,693
Santa Cruz	26	$368,247	$145,478	$222,769
Stanislaus	52	$783,954	$342,990	$440,964
Tulare	35	$531,206	$257,372	$273,834
Yolo	6	$50,184	$18,066	$32,117
Totals	**2,161**	**$29,011,520**	**$13,762,150**	**$15,249,370**

Had LIHP been in place in the Non-Legacy counties for all of FY 2010-11, an estimated 2,161 clients would have shifted from ADAP to LIHP and ADAP would have realized estimated unadjusted net savings of $15.25 million, consisting of $29.01 million in reduced expenditures less $13.76 million in reduced rebate revenue.

b) OA calculated the following percentages: 1) client shift to total clients served during FY 2010-11; 2) reduced expenditures to total ADAP FY 2010-11 expenditures; 3) reduced rebate revenue to total ADAP FY 2010-11 expenditures; and 4) net savings to total ADAP FY 2010-11 expenditures.

OA used different denominators to calculate the client shift and the net savings percentages. The client shift percentage was calculated using the FY 2010-11 clients served of 39,256, whereas the expenditure, rebate, and net savings percentages were calculated using the actual FY 2010-11 expenditure of $449,289,428 million as the denominator. Thus, net savings are calculated independently of client shift.

Per **Table 5**, had LIHP been in place in the Non-Legacy counties in FY 2010-11, ADAP would have shifted 5.51 percent of its clients served to LIHP (2,161 potentially LIHP-eligible ADAP clients in the Non-Legacy counties divided by 39,246 total ADAP clients served in FY 2010-11) and realized net savings of 3.39 percent ($15,249,370 in estimated FY 2010-11 savings divided by FY 2010-11 expenditures of

$449,289,428), consisting of 6.46 percent in reduced expenditures and 3.06 percent in reduced rebate revenue. The denominator figures are show in **Table 5** as "Fiscal Year (FY) Totals."

TABLE 5: LIHP IMPACT PERCENTAGES FOR THE NON-LEGACY COUNTIES USING FY 2010-11 DATA

Fiscal Year 2010-11	Client Shift	Reduced Expenditures	Reduced Rebate Revenue	Net Savings
LIHP Impact Estimates	2,161	$29,011,520	$13,762,150	$15,249,370
Fiscal Year 2010-11 Totals	39,246	$449,289,428*	$449,289,428*	$449,289,428*
Percents to Apply	**5.51%**	**6.46%**	**3.06%**	**3.39%**

*FY 2010 -11 total expenditures used as denominator in determining percentages.

c) OA applied the percentages in **Table 5** to estimated FYs 2011-12 and 2012-13 expenditures and clients served to derive the preliminary unadjusted impact numbers for the Non-Legacy counties shown in **Table 6** (below). To estimate the unadjusted net savings impact for FY 2011-12, OA multiplied the FY 2011-12 expenditure estimate of $484,790,798 by the FY 2010-11 expenditure percentage of 6.46 percent to derive reduced expenditures of $31.30 million. To calculate the unadjusted reduced rebate revenue, OA multiplied the FY 2011-12 expenditure estimate by the FY 2010-11 rebate percentage of 3.03 percent for an estimated $14.85 million, resulting in an unadjusted net savings for FY 2011-12 of $16.45 million. OA applied the same methodology to estimate the net savings for FY 2012-13, but used the FY 2012-13 expenditure estimate of $553,903,775 to derive the net unadjusted savings of $18.80 million given in **Table 6**.

TABLE 6: ESTIMATED LIHP IMPACTS IN THE NON-LEGACY COUNTIES PRIOR TO ADJUSTMENTS

IMPACTS	FY 2011-12	FY 2012-13
Client Shift	**2,257**	**2,367**
Reduced Expenditures	$31,303,914	$35,766,678
Reduced Rebate Revenue	-$14,849,589	-$16,966,584
Net Savings	**$16,454,325**	**$18,800,094**

See **Appendix A**, page 42, for the expenditure estimates used in this Assumption, which were determined by using the upper bound of ADAP's Medi-Cal(-) expenditure model. Adjustments to these initial expenditure, rebate, and net savings figures are detailed in the section entitled, "Adjustments to Initial Expenditure, Rebate, and Net Savings Estimates" below.

To estimate the unadjusted client shift in the Non-Legacy counties for FY 2011-12, OA first estimated the number of clients to be served by ADAP in FY 2011-12 using a regression procedure similar to that used for estimating ADAP expenditures, resulting in an estimated **40,988** clients. OA then calculated the number of

potentially LIHP-eligible clients in the Non-Legacy counties who would shift over to LIHP by multiplying the FY 2011-12 clients served estimate of **40,988** by the FY 2010-11 client shift percentage of 5.51 percent for an unadjusted estimated **2,257** clients shifting to LIHP in the Non-Legacy counties in FY 2011-12, as shown in **Table 6** (page 14). OA applied the same methodology to estimate the client shift for FY 2012-13, but used the FY 2012-13 clients served estimate of **42,986** to derive an unadjusted client shift in the Non-Legacy counties of **2,367**.

The term "client shift" means that ADAP LIHP-eligible clients shift over to LIHP over the course of a FY. Until they actually shift over, ADAP incurs expenditures for them and thus, they are still considered to be ADAP clients for that FY. Adjustments to these client shift estimates are detailed in the section entitled "Adjustments to Client Shift Estimates" starting on page 20.

Adjustments to Initial Expenditure, Rebate, and Net Savings Estimates

To determine the final net savings impact of the Non-Legacy LIHPs on ADAP, OA adjusted the initial expenditure and rebate reduction estimates to account for LIHP program ramp-up time. Per DHCS, implementation dates for the Non-Legacy counties vary between January 1, 2012 and August 1, 2012. While the Non-Legacy counties with the highest impact, including Riverside, San Bernardino, and the CMSP counties, implemented LIHP on January 1, 2012 and account for about 62 percent of clients shifting over to LIHP in the Non-Legacy counties, the rest of the Non-Legacy counties have implementation dates starting April 1, 2012 or later and account for the remaining 38 percent of clients shifting. Because an impact analysis using so many different implementation dates would prove complex and unwieldy, OA took a weighted average of the client shift among all of the Non-Legacy counties to calculate an average Non-Legacy county start date of February 1, 2012.

However, LIHP-eligible ADAP clients will not immediately shift over to LIHP upon being screened for LIHP, as was assumed in the *2012-13 Governor's Budget*. OA estimated that the time period between when an ADAP client is screened for potential LIHP eligibility and subsequently enrolled in LIHP to be 90 days, which takes into account the following processes: 1) ADAP clients have 30 days after being screened for potential LIHP eligibility by ADAP on their recertification date to apply to LIHP; and 2) on average it takes approximately 60 days for eligibility determination by LIHP. ADAP will still be paying for the drugs for these screened clients during this 90-day period before clients are enrolled in LIHP (with the exception of the unknown portion of expenditures for which back-billing may be possible). Because of this delay in realizing savings, OA did not start accounting for expenditure and rebate reductions for the Non-Legacy counties until May 1, 2012 (90 days after the February 1, 2012 average implementation date).

Furthermore, not all LIHP-eligible ADAP clients in the Non-Legacy counties will enroll into LIHP on May 1, 2012. They will be screened on their ADAP recertification date, which is based upon birth date. Analysis of FY 2010-11 data showed that the birth month of such clients to be fairly equally distributed across the 12 months of the year.

Therefore, OA assumed that one-twelfth of potentially LIHP-eligible clients would be screened for LIHP each month for the 12 months of ADAP screening, which takes place from February 2012 through January 2013. However, to account for the three month delay between screening and enrollment, OA assessed the impacts of the Non-Legacy LIHPs on ADAP for the 12-month period of May 2012 through April 2013, which consists of the last two months of FY 2011-12 and the first ten months of FY 2012-13.

There are two distinct phases involved in calculating the impacts of the Non-Legacy LIHP counties on ADAP. The first phase is the 12-month transition period of May 2012 through April 2013, when an average of one-twelfth of LIHP-eligible ADAP clients shift over to LIHP each month. This process is referred to as "ramp-up" because, as clients shift over to LIHP, ADAP realizes a steadily increasing or ramped-up amount of net savings. After the end of this 12-month transition period, the bulk of ADAP LIHP-eligible clients will have shifted over to LIHP, and the amount of LIHP savings becomes relatively stable.

OA calculated the expenditure and rebate ramp-ups separately for FYs 2011-12 and 2012-13, as described below. In order to more accurately estimate the monthly expenditure and rebate reductions due to LIHP in the Non-Legacy counties, OA first calculated the proportion of each month of FY 2010-11 expenditures to total FY 2010-11 expenditures and applied those percentages to total FYs 2011-12 and 2012-13 predicted expenditures to get a month-by-month breakdown of predicted expenditures and rebate. The resulting month-by-month expenditure predictions were used to calculate the monthly expenditure and rebate reductions delineated below.

FY 2011-12 Expenditure and Rebate Reductions

Expenditure Reductions. Because potentially LIHP-eligible ADAP clients in the Non-Legacy counties will not start leaving ADAP until May 2012, ADAP would only realize a small part of the unadjusted estimated **$31.30** million in FY 2011-12 expenditure reductions shown in **Table 6** (page 14). To estimate that part, OA apportioned the predicted monthly expenditure reductions based upon the predicted monthly expenditure estimates for FY 2011-12, as shown in **Table 7** (next page). For May and June, this resulted in **$5.5** million as the portion of the FY 2011-12 expenditure reduction that could be realized for those two months. However, since not all clients would be enrolled into LIHP as of May 2012 (clients will be screened at their next ADAP recertification), this **$5.5** million had to be adjusted to account for the client transition to LIHP. For May and June, OA estimated that one-twelfth of all potentially LIHP-eligible ADAP clients in the Non-Legacy counties would in fact transition to LIHP each month. Because the reduced expenditures of these clients leaving ADAP are cumulative, each successive month includes expenditure reductions realized by clients who were already enrolled into LIHP during the previous ramp-up month(s).

TABLE 7: EXPENDITURE REDUCTIONS IN THE NON-LEGACY COUNTIES FOR FY 2011-12				
Month	**Estimated Monthly Expenditures**	**Estimated Monthly Expenditure Reduction**	**Ramp-Up Multiplier**	**Expenditure Reduction Ramp-Up**
JUL 2011	$38,703,855	$2,499,186	0	$0
AUG	$38,785,798	$2,504,477	0	$0
SEP	$38,467,915	$2,483,950	0	$0
OCT	$37,468,475	$2,419,415	0	$0
NOV	$39,945,893	$2,579,386	0	$0
DEC	$39,820,432	$2,571,285	0	$0
JAN 2012	$40,667,989	$2,626,014	0	$0
FEB	$39,697,886	$2,563,372	0	$0
MAR	$44,548,303	$2,876,573	0	$0
APR	$40,908,834	$2,641,565	0	$0
MAY	$42,290,899	$2,730,808	1/12	$227,567
JUN	$43,484,520	$2,807,883	2/12	$467,980
Totals	**$484,790,798**	**$31,303,914**		**$695,548**

For example, per **Table 7**, in May 2012, ADAP would have incurred an estimated $42.29 million in expenditures if LIHP were not in place. If all potentially LIHP-eligible ADAP clients in the Non-Legacy counties had enrolled in LIHP as of May 2012, ADAP would have realized an approximate $2.73 million reduction in expenditures for that month. However, because of the annual recertification process, OA estimated that only one-twelfth of these clients would in fact shift to LIHP in May, resulting in pro-rated savings of $227,567 [($2.73 million x (1/12)]. For June, ADAP would have realized $2.81 million in reduced expenditures if all potentially LIHP-eligible clients had shifted to LIHP. But not only do a further one-twelfth of such clients shift to LIHP in June, the one-twelfth which shifted in May would also generate additional savings to ADAP in June. Thus, estimated reduced expenditures for June consisted of two-twelfths of potential savings, or $467,980 [$2.81 million x (2/12)]. Estimating expenditure reductions in this way leads to total reduced expenditures for the final two months of FY 2011-12 of $695,548.

Rebate Reductions. Applying the same methodology to rebate revenue led to an estimated FY 2011-12 rebate reduction of **$329,946**. See **Table 8**.

TABLE 8: REBATE REDUCTIONS IN THE NON-LEGACY COUNTIES FOR FY 2011-12			
Month	**Estimated Monthly Rebate Reduction**	**Ramp-Up Multiplier**	**Rebate Reduction Ramp-Up**
JUL 2011	-$1,185,535	0	$0
AUG	-$1,188,045	0	$0
SEP	-$1,178,308	0	$0
OCT	-$1,147,694	0	$0
NOV	-$1,223,580	0	$0
DEC	-$1,219,737	0	$0
JAN 2012	-$1,245,698	0	$0
FEB	-$1,215,983	0	$0
MAR	-$1,364,556	0	$0
APR	-$1,253,075	0	$0
MAY	-$1,295,409	1/12	-$107,951
JUN	-$1,331,971	2/12	-$221,995
Totals	**-$14,849,589**		**-$329,946**

However, OA could not apply this $329,946 in reduced rebate to the $695,548 in reduced expenditures to get a net savings amount for FY 2011-12 because there is a six-month delay between when ADAP incurs expenditures and when ADAP actually receives the rebate for those expenditures. Therefore, this $329,946 in reduced rebate was accounted for in FY 2012-13, as detailed further below.

FY 2012-13 Expenditure and Rebate Reductions

Expenditure Reductions. **Table 9** (next page) shows the monthly estimated expenditure reductions for FY 2012-13. By applying the same methodology used to estimate expenditure reductions for FY 2011-12, OA estimated that ADAP would realize an estimated **$24.96** million in expenditure reductions for FY 2012-13.

TABLE 9: EXPENDITURE REDUCTIONS IN THE NON-LEGACY COUNTIES FOR FY 2012-13				
Month	**Estimated Monthly Expenditures**	**Estimated Monthly Expenditure Reduction**	**Ramp-Up Multiplier**	**Expenditure Reduction Ramp-Up**
JUL 2012	$44,221,572	$2,855,476	3/12	$713,869
AUG	$44,315,197	$2,861,521	4/12	$953,840
SEP	$43,951,996	$2,838,069	5/12	$1,182,529
OCT	$42,810,073	$2,764,332	6/12	$1,382,166
NOV	$45,640,679	$2,947,110	7/12	$1,719,148
DEC	$45,497,331	$2,937,854	8/12	$1,958,569
JAN 2013	$46,465,718	$3,000,385	9/12	$2,250,288
FEB	$45,357,315	$2,928,813	10/12	$2,440,677
MAR	$50,899,219	$3,286,665	11/12	$3,012,776
APR	$46,740,899	$3,018,154	12/12	$3,018,154
MAY	$48,319,994	$3,120,119	12/12	$3,120,119
JUN	$49,683,781	$3,208,181	12/12	$3,208,181
Totals	**$553,903,775**	**$35,766,678**		**$24,960,317**

Per **Table 9**, ADAP does not start realizing full expenditure reductions until April 2013, the last month of ramp-up.

Rebate Reductions. Applying the same methodology to rebate revenue led to an estimated FY 2012-13 rebate reduction of $11.84 million for FY 2012-13. See **Table 10**.

TABLE 10: REBATE REDUCTIONS IN THE NON-LEGACY COUNTIES FOR FY 2012-13			
Month	**Estimated Monthly Rebate Reduction**	**Ramp-Up Multiplier**	**Rebate Reduction Ramp-Up**
JUL 2012	-$1,354,548	3/12	-$338,637
AUG	-$1,357,415	4/12	-$452,472
SEP	-$1,346,290	5/12	-$560,954
OCT	-$1,311,312	6/12	-$655,656
NOV	-$1,398,016	7/12	-$815,509
DEC	-$1,393,625	8/12	-$929,083
JAN 2013	-$1,423,288	9/12	-$1,067,466
FEB	-$1,389,336	10/12	-$1,157,780
MAR	-$1,559,090	11/12	-$1,429,166
APR	-$1,431,717	12/12	-$1,431,717
MAY	-$1,480,086	12/12	-$1,480,086
JUN	-$1,521,860	12/12	-$1,521,860
Total	**-$16,966,584**		**-$11,840,387**

Per **Table 11**, because of the six-month delay in collecting rebate, the total rebate reduction to be applied against the FY 2012-13 reduced expenditures consists of the final two months of FY 2011-12 (see **Table 8**, page 18) and the first six months of FY 2012-13 (see **Table 10**), or $4.08 million in rebate reduction. The remaining six months of FY 2012-13 rebate (for January-June 2013) would be applied in FY 2013-14.

TABLE 11: DELAY IN FINAL REBATE REDUCTIONS FOR FY 2012-13

Month/Yr *Incurred*	Rebate Reduction	Month/Yr *Applied*
JAN 2012	$0	JUL 2012
FEB	$0	AUG 2012
MAR	$0	SEP 2012
APR	$0	OCT 2012
MAY	-$107,951	NOV 2012
JUN	-$221,995	DEC 2012
JUL	-$338,637	JAN 2013
AUG	-$452,472	FEB 2013
SEP	-$560,954	MAR 2013
OCT	-$655,656	APR 2013
NOV	-$815,509	MAY 2013
DEC	-$929,083	JUN 2013
Total	**-$4,082,258**	

Adjustments to Client Shift Estimates

As explained in the expenditure and rebate ramp-up methodologies, ADAP clients will shift to the Non-Legacy LIHPs over a 12-month period, from May 2012 through April 2013, with one-twelfth of clients shifting each month. This 12-month period spans portions of both FYs 2011-12 and 2012-13. However, the unadjusted client shift estimates of 2,257 clients for FY 2011-12 and 2,367 for FY 2012-13 given in **Table 6** (page 14) were calculated as if ramp-up occurred either during FY 2011-12 ***or*** during FY 2012-13. This means that the 2,367 clients who were estimated to shift over in FY 2012-13 include the 2,257 clients estimated to shift over in FY 2011-12 with an additional 110 new LIHP-eligible ADAP clients factored in for FY 2012-13 for client growth (110 = 2,367–2,257). However, the monthly LIHP client ramp-up will actually occur during parts of each FY, with each new month including the previously shifted clients. To account for the client ramp-up divided between FYs, OA pro-rated the unadjusted client shift estimates for both FYs (from **Table 6**, page 14) based upon when, over the 12-month ramp-up period, ADAP clients are projected to shift to LIHP.

During FY 2011-12, LIHP-eligible clients will only shift over during May and June 2012, the final two months. Therefore, only two-twelfths of the 2,257 clients initially estimated

to be LIHP eligible for FY 2011-12 shift during May and June, or 376 clients (2,257 * (2/12) = 376).

FY 2012-13 is more complex. During the ten remaining months of ramp-up (the first ten months of FY 2012-13), ten-twelfths of the FY 2012-13 client shift of 2,367, or 1,973 potentially LIHP–eligible clients, are estimated to shift over to LIHP (2,367 * 10/12 = 1,973). As of April 2013, all potentially LIHP-eligible ADAP clients have shifted to LIHP and ramp-up ceases. However, ADAP will still be screening potentially new ADAP clients for LIHP, and some number of these potential clients will be enrolled into LIHP instead. To account for the movement of these potential new clients over the final two months of FY 2012-13, OA pro-rated the client growth factor of 110 clients from FY 2011-12 to FY 2012-13 calculated above and estimated that 18 potential ADAP clients will actually shift over to LIHP for May and June 2013 (110 2/12 = 18).

Thus, in the Non-Legacy counties, for FY 2011-12, an estimated 376 clients will shift to LIHP, and for FY 2012-13, an estimated 1,991 will shift (1,973 + 18 = 1,991), for a total shift across both FYs of 2,367, which is the FY 2012-13 unadjusted number of clients shifting over to LIHP (**Table 6**, page 14).

Final Adjusted Impact Estimates

Table 12 shows the final estimated impacts of LIHP on ADAP for both FYs 2011-12 and 2012-13.

TABLE 12: FINAL ADJUSTED LIHP IMPACTS IN THE NON-LEGACY COUNTIES

Impact Estimates	FY 2011-12	FY 2012-13
Client Shift	376	1,991
Reduced Expenditures	$695,548	$24,960,317
Reduced Rebate Revenue	$0	-$4,082,258
Net Savings	**$695,548**	**$20,878,059**

Per **Table 12**, for FY 2011-12, OA estimated that in the Non-Legacy LIHP counties, ADAP would realize net savings of $695,548, consisting entirely of expenditure reductions, and a shift of 376 clients. For FY 2012-13, OA estimated that ADAP would realize a net savings of $20.87 million for the Non-Legacy LIHP counties, representing reduced expenditures of $24.96 million less reduced rebate revenue of $4.08 million, and a shift of 1,991 clients.

No Adjustments Made

OA made no adjustments to the impact of LIHP on ADAP for the following areas:

a) LIHP Co-Pays: Santa Cruz is the only Non-Legacy county planning to enact LIHP medication co-pays at this time. However, three Legacy counties (Alameda,

Orange, and Ventura) plan to enact medication co-pays for new LIHP enrollees, including those transitioning from ADAP.

OA recently received guidance from HRSA that ADAP may use RW and rebate funds to pay for LIHP medication co-pays for its clients who transition over to LIHP. OA will work with DHCS and LIHPs to determine if it is feasible for ADAP to pay LIHP medication co-pays. Due to the various issues to be addressed, OA cannot estimate the impact of LIHP medication co-pays at this time.

b) Retroactive Billing: Per DHCS, LIHP enrollment is retroactive to the first of the month in which a client applied for LIHP. OA is investigating the possibility of retroactively billing the county LIHPs for drugs paid for by ADAP between the date of LIHP enrollment determination back to the retroactive eligibility start date as determined by the county. Two issues which complicate developing a mechanism for retroactively billing expenditures include determining: 1) which ADAP clients have actually shifted over to a specific county LIHP; and 2) the actual method or methods to use for billing each LIHP.

c) Income Qualification. LIHP bases eligibility upon the FPL percent of family income. However, ADAP currently only collects gross income data, which represents the gross income of the individual ADAP client, and does not collect family income or size. A client whom this analysis considers to be eligible for LIHP based upon reported gross income (assuming gross income is individual income for a single person family) may in fact not meet the LIHP household income eligibility requirements if they have a higher family income. Likewise, other clients whom this analysis considers to be ineligible for LIHP based on individual gross income but who have many dependents might actually be eligible for LIHP. At this time OA does do not have sufficient ADAP data to determine: 1) whether or not this income qualification disparity will have a measurable impact on ADAP savings; and 2) how to adjust for any disparities that do exist.

d) Enrollment Caps. At this time, none of the Legacy counties have actually enacted enrollment caps. Several counties have indicated that they will wait and determine their actual LIHP costs before considering implementing caps.

If OA receives new information necessitating adjustments to any of the above, OA will make the adjustments in a subsequent estimate.

NMA 2. Additional 2012 RW Federal Grant Funds

On April 9, 2012, OA received the Notice of Award (NOA) for 2012 ADAP Earmark and RW Part B ADAP Supplemental federal funds. In the *2012-13 Governor's Budget*, OA anticipated flat federal ADAP Earmark funding; however, ADAP received an increase of $2,606,818 resulting in a total of $105,179,281 in ADAP Earmark local assistance funding. In addition, OA applied for and received funding from the 2012 RW Part B ADAP Supplemental Grant. This supplemental grant is for states with a waiting list or

those that anticipate instituting a waiting list or other cost-saving strategies in 2012. OA received one-time funding of $8,425,807 for the 2012 RW grant year (April 1, 2012 – March 31, 2013). The *2012-13 May Revision* assumes these federal funds will be spent in the budget year.

Revised Major Assumptions

RMA 1. Impact of the Ten "Legacy" LIHP Counties on ADAP

In the 2012-13 Governor's Budget, OA estimated savings due to ADAP clients transitioning to the ten Legacy LIHPs. The Legacy counties include: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. These ten counties represent the bulk of ADAP clients (79 percent of all ADAP clients during FY 2010-11).

As already indicated in **NMA 1**, since calculating the *2012-13 Governor's Budget* impacts of the Legacy county LIHPs on ADAP, OA received updated ADAP and LIHP implementation information which necessitated making several changes to the *2012-13 Governor's Budget* methodology, including the following: 1) adding ADAP Medicare clients as potentially LIHP eligible in addition to ADAP-only and private insurance clients; 2) using current FY 2010-11 data instead of CY 2010 data as a basis for estimating the impact of LIHP on ADAP; 3) using the current 2012 FPL levels instead of 2011 FPL levels to determine client eligibility for LIHP; and 4) taking into account the approximate 90-day delay between when ADAP clients are screened for LIHP and the start of ADAP savings to account for the time it takes for ADAP LIHP-eligible clients to apply to and be enrolled in LIHP.

Specific to the ten Legacy counties, two further impact changes include: 1) accounting for the delay in the screening implementation date in Alameda and Los Angeles Counties, now estimated to be July 1, 2012; and 2) including the administrative costs charged by ADAP's PBM to modify their existing system to include LIHP screening. The same methodology outlined in **NMA 1**, supplemented by accounting for the Los Angeles and Alameda implementation delays and the PBM administrative charges, was used to update the impact of LIHP on the ten Legacy counties. Summary results are provided below.

Los Angeles and Alameda Implementation Delay. OA required ADAP coordinators and RW Part B contractors in the ten Legacy counties to create plans for implementing LIHP eligibility screening. Eight of the Legacy counties implemented LIHP screening during or before January 2012. However, Los Angeles County notified OA in their January 17, 2012 LIHP screening plan update that they would not be ready to implement LIHP screening before July 2012. Alameda indicated in their March report that they are on target with implementing LIHP screening July 1, 2012. Alameda and Los Angeles Counties account for a significant amount of the estimated savings for FYs 2011–12 and 2012–13. OA accounted for both the implementation start date delay in these two counties and the 90-day delay between LIHP screening and LIHP enrollment by moving

the start of clients actually enrolling into LIHP in Los Angeles and Alameda Counties (and hence the start of savings to ADAP due to LIHP) from January 1, 2012 to October 1, 2012.

For Los Angeles and Alameda Counties, OA estimated a net FY 2012-13 savings of $33.53 million, consisting of $35.53 million in reduced expenditures and $2 million in reduced rebate (see **Table 13**). OA also estimated a client shift of 5,313. There were no FY 2011-12 impacts.

TABLE 13: FINAL ADJUSTED LIHP IMPACTS IN LOS ANGELES/ALAMEDA COUNTIES

Impact Estimates	FY 2011-12	FY 2012-13
Client Shift	0	5,313
Reduced Expenditures	$0	$35,527,355
Reduced Rebate Revenue	$0	-$2,001,644
Net Savings	**$0**	**$33,525,711**

Eight Other Legacy Counties. For the eight Legacy counties which implemented LIHP by the end of January 2012, OA continued to use an averaged implementation date of January 1, 2012 for our estimate. OA estimated a net FY 2011-12 savings of $2.05 million, consisting entirely of reduced expenditures. OA then deducted the $60,000 administrative charge submitted by OA's PBM to modify its existing data system to include LIHP screening, resulting in a final net savings for FY 2011-12 of $1.99 million.

For FY 2012-13, OA estimated a new savings of $33.18 million, consisting of $40.38 million in reduced expenditures and $7.20 million in reduced rebate (see **Table 14**). OA also estimated the client shift in these Legacy counties to be 865 clients in FY 2011-12 and an additional 2,764 clients in FY 2012-13.

TABLE 14: FINAL ADJUSTED LIHP IMPACTS IN THE EIGHT LEGACY COUNTIES

Impact Estimates	FY 2011-12	FY 2012-13
Client Shift	865	2,764
Reduced Expenditures	$2,047,497	$40,380,961
Reduced Rebate Revenue	$0	-$7,197,428
Administrative Costs	-$60,000	
Net Savings	**$1,987,497**	**$33,183,533**

Table 15 shows the combined estimated impacts of LIHP for all ten Legacy counties (see **Tables 13** and **14**).

TABLE 15: FINAL ADJUSTED LIHP IMPACTS FOR THE 10 LEGACY COUNTIES		
Impact Estimates	**FY 2011-12**	**FY 2012-13**
Client Shift	865	8,076
Reduced Expenditures	$2,047,497	$75,908,316
Reduced Rebate Revenue	$0	-$9,199,072
Administrative Costs	-$60,000	$0
Net Savings	**$1,987,497**	**$66,709,244**

Due to new information and changes in the LIHP methodology enumerated in this **RMA 1**, ADAP saw changes in its net savings and client shifts previously calculated for the ten Legacy counties in the *2012-13 Governor's Budget* for both FYs 2011-12 and 2012-13. **Table 16** shows the *2012-13 Governor's Budget* LIHP impacts in the ten Legacy counties.

TABLE 16: *2012-13 GOVERNOR'S BUDGET* ESTIMATED LIHP IMPACTS FOR THE 10 LEGACY COUNTIES		
Impact Estimates	**FY 2011-12**	**FY 2012-13**
Client Shift	4,800	5,272
Reduced Expenditures	$19,902,871	$139,903,677
Reduced Rebate Revenue	$0	-$33,078,128
Net Savings	**$19,902,871**	**$106,825,549**

Table 17 gives the differences between the current LIHP impact estimates in the ten Legacy counties and the *2012-13 Governor's Budget*.

TABLE 17: LIHP IMPACT CHANGES FROM THE *2012-13 GOVERNOR'S BUDGET* IN THE 10 LEGACY COUNTIES		
Impact Estimates	**FY 2011-12**	**FY 2012-13**
Client Shift	(3,935)	2,804
Reduced Expenditures	-$17,855,374	-$63,995,361
Reduced Rebate Revenue	$0	$23,879,056
Administrative Costs	-$60,000	
Net Savings Loss	**-$17,915,374**	**-$40,116,305**

Because of the new information received and methodological changes made in this **RMA 1**, most importantly the delay of LIHP implementation in Los Angeles and Alameda Counties, for FY 2011-12, OA estimated a reduction in the client shift of 3,935 clients and reduced net savings of $17.92 million. For FY 2012-13, while OA saw an increase in its client shift of 2,804, net savings were reduced by $40.12 million. As previously noted, clients shift over to LIHP during the course of the FY, but, until they do shift, ADAP continues to pay for their drugs. Thus, while we are seeing an increase in

client shift in FY 2012-13, we are not seeing an increase in net savings because these clients are staying enrolled in ADAP longer in FY 2012-13 than assumed in the *2012-13 Governor's Budget* and thus incurring more expenditures than previously calculated.

No Adjustments Made

OA made no adjustments to the impact of LIHP on ADAP in the ten Legacy counties for retroactive billing and for ADAP paying for LIHP co-pays. As noted in **NMA 1**, OA is currently investigating the mechanisms which would need to be put into place for both of these processes.

In addition, there are numerous other uncertainties currently surrounding LIHP implementation in the Legacy counties, including the following: 1) the actual implementation date for Los Angeles and Alameda Counties; 2) changes to the income level eligibility requirements; and 3) the impact of LIHP enrollment caps and waiting lists on RW clients and thus how many ADAP clients will transition to LIHPs. OA may need to revise its methodology and its impact calculations based upon these uncertainties.

RMA 2. Delayed OA-PCIP Implementation

OA implemented OA-PCIP to pay PCIP premiums, deductibles, and co-pays for PCIP-eligible ADAP clients in place of ADAP paying the full cost of medications for these clients. In the *2012-13 Governor's Budget*, OA anticipated a November 1, 2011 OA-PCIP implementation date, which consisted of paying both PCIP premiums and receiving ADAP savings at the same time. The following three assumptions address savings to ADAP due to OA-PCIP:

- Delay in OA-PCIP Implementation (**RMA 2**): ADAP savings resulting from the transition of PCIP-eligible ADAP clients to OA-PCIP;
- PCIP Premiums (**CA 1**): Cost of paying PCIP premiums; and
- LIHP Implementation (**CA 2**): A subsequent reduction in OA-PCIP caseload due to implementation of LIHP.

The Managed Risk Medical Insurance Board (MRMIB) and OA finalized an interagency agreement to implement OA-PCIP and OA began accepting and processing OA-PCIP applications in November 2011. However, due to delays in the enrollment process, the earliest that clients became fully enrolled in OA-PCIP was January 1, 2012, not November 2011 as assumed in the *2012-13 Governor's Budget*. Although clients were enrolled in OA-PCIP in January 2012, a system had not yet been established that would provide clients with easy access to local PCIP pharmacies. Thus, ADAP continued to be charged the full cost of these medications for OA-PCIP clients enrolled in ADAP as if they were ADAP-only clients, instead of being charged the lower PCIP deductibles and co-pays. As a result, drug expenditure savings for these clients will not be achieved until May 2012 when proper billing can be established with ADAP/PCIP pharmacies (**RMA 2**, above). Finally, reductions in OA-PCIP caseload and savings due

to LIHP will not take place until May 2012 (**CA 2** above, and as described in **NMA 1** and **RMA 1**).

In addition to changes impacting the three above assumptions, based on OA-PCIP enrollment from January through February 2012, OA updated the number of clients enrolling and the rate of enrollment. The estimated percent of PCIP-eligible ADAP clients enrolling in PCIP was reduced from 10 percent to 4 percent and factored into the above three assumptions.

OA also adjusted the ramp-up rates in the *2012-13 May Revision* due to the delay in OA-PCIP implementation. In the *2012-13 Governor's Budget*, OA assumed a quarterly "0-5-28-33" percent ramp-up rate for OA-PCIP implementation in FY 2011-12 with each number representing the estimated percentage of PCIP-eligible ADAP clients enrolling in OA-PCIP per quarter (starting with Quarter 1 of FY 2011-12).

Thus, to adjust the ADAP estimate due to OA-PCIP for FY 2011-12, OA updated the three assumptions, as follows:

- Delay in OA-PCIP Implementation (**RMA 2**): Pushed back the expenditure savings ramp-up rate to "0-0-0-50" percent per quarter for savings from averted drug expenditures offset by drug deductibles and co-pays because of the May 2012 start date for including PCIP pharmacies in the ADAP network (instead of January 2012 when OA-PCIP enrollment begins);
- PCIP Premiums (**CA 1**): Pushed back the client/premium ramp-up rate to "0-0-25-25" percent per quarter for capturing premium payment expenditures using the same reduction in annual premiums ($4,518 to $3,795) as in the *2012-13 Governor's Budget* because of the delayed enrollment date (from November 2011 to January 2012); and
- LIHP Implementation (**CA 2**): Pushed back the transition to LIHP for the estimated 32 percent of LIHP-eligible OA-PCIP clients. This reduced OA-PCIP caseload and savings because of the delay in clients enrolling in LIHP **(RMA 1)**. This also takes into consideration enrollment of clients into the new Non-Legacy county LIHPs **(NMA 1)**.

Any remaining ramp-up percentages (from 100 percent, e.g., "0-0-25-25") were captured in the FY 2012-13 estimate.

For comparison purposes, the same table structure was used in the *2012-13 May Revision* as in the *2012-13 Governor's Budget.* This also meant that revised and continuing assumptions were combined in this section and added to the tables (**RMA 2**, **CA 1**, and **CA 2**).

OA-PCIP Adjustments: Overall Estimate Methodology and Summary for **RMA 2** and **CA 1** and **2**:

To estimate the FYs 2011-12 and 2012-13 net savings, OA used the methodology as stated in the *2012-13 Governor's Budget* (see RMA 1–3) and compared it against

January through February 2012 OA-PCIP actuals. Expenditures and revenue were computed separately for two components:

1. Component 1 (Majority impact): Voluntary co-enrollment of an estimated 10 percent of eligible ADAP-only clients into OA-PCIP; and
2. Component 2 (Minor impact): Voluntary co-enrollment of any other HIV-infected PCIP clients who were not previously in ADAP into ADAP (to pay pharmaceutical deductibles and co-pays) and OA-PCIP.

The following summary tables (**Table 18 and Table 19**, pages 28 and 29) show the revised impact of the three PCIP adjustments on premiums, expenditures, rebate revenue, net costs/savings, and clients for FY 2011-12 (final net savings = **$180,187**) and FY 2012-13 (final net savings = **$3,437,431**). "Unadjusted Estimate" (first unnumbered row of both tables) refers to updating the premium and drug expenditures, rebate, and net savings based on FY 2010-11 data (with no other adjustments) using the revised expenditure estimate generated by the regression model. Then, the changes to premiums, drug expenditures, rebate, and total net cost/savings are shown for each OA-PCIP issue sequentially and adjusted for any prior issues. For example, as mentioned above, reductions to OA-PCIP due to LIHP implementation **(CA 2)** takes into consideration the delay in OA-PCIP implementation **(RMA 2)** and reduced PCIP premiums **(CA 1)** in that particular order. The delay also included a change in the estimated number of PCIP-eligible ADAP clients enrolling in PCIP from 10 percent to 4 percent, based on actual OA-PCIP data. The totals in the bottom row show the final premiums, drug expenditures, rebate, and net savings after all adjustments were made to the unadjusted estimate. However, the FCS will only show the internal components of the table for premiums, drug expenditures, and rebate revenue for the applicable months and none of the row or column totals.

Compared to the *2012-13 Governor's Budget* net savings of $1,784,671, for FY 2011-12, OA now estimates a net savings of **$180,187** ($263,618 in premiums, $549,490 in reduced drug expenditures and $190,916 in loss of rebate revenue), which equates to a reduction in net savings of $1,604,484 due to the three OA-PCIP issues. In the tables below, total estimate = premiums + drug expenditures – rebate revenue.

TABLE 18: SUMMARY OF PCIP CHANGES, FY 2011-12

ISSUE	PREMIUMS	DRUG EXPEND$	REBATE REVENUE	TOTAL ESTIMATE	CLIENTS
Unadj. Estimate	$2,582,141	-$11,082,363	-$2,101,811	-$6,398,411	1,290
Delay: RMA 2	-$2,203,729	$10,277,487	$1,947,946	$6,125,813	-1016
Premiums: CA 1	-$60,603	$0	$0	-$60,603	0
LIHP: CA 2	-$54,190	$255,385	$48,181	$153,014	-88
TOTAL	**$263,618**	**-$549,490**	**-$105,685**	**-$180,187**	**186**

Negative (-) expenditures and (-) net = expenditure reduction; and negative (-) revenue = rebate loss.

For FY 2012-13, the net savings of **$3,437,431** consists of $1.19 million in premiums, $5.83 million in reduced drug expenditures, and $1.20 million in loss of rebate revenue. This represents a reduction in net savings of $1,134,624 from the *2012-13 Governor's Budget* net savings of $4,572,055.

TABLE 19: SUMMARY OF PCIP CHANGES, FY 2012-13

ISSUE	PREMIUMS	DRUG EXPEND$	REBATE REVENUE	TOTAL ESTIMATE	CLIENTS
Unadj. Estimate	$6,102,520	-$28,898,010	-$7,591,875	-$15,203,615	1,351
Delay: RMA 2	-$3,813,368	$18,728,519	$5,541,943	$9,373,208	-779
Premiums: CA 1	-$366,610	$0	$0	-$366,610	0
LIHP: CA 2	-$736,951	$4,344,041	$847,504	$2,759,585	-362
TOTAL	**$1,185,592**	**-$5,825,450**	**-$1,202,427**	**-$3,437,431**	**210**

Negative (-) expenditures and (-) net = expenditure reduction; and negative (-) revenue = rebate loss.

RMA 3. Institution of a New Client Cost-Sharing Policy

This Assumption was included in the *2012-13 Governor's Budget* to increase ADAP client SOC to the maximum percentage allowable under federal law for specified ADAP clients, with an assumed July 1, 2012 implementation date. For the *2012-13 May Revision*, OA updated the SOC estimates by eliminating the SOC for ADAP clients with private insurance due to antiretroviral (ARV) manufacturer's co-pay assistance programs, delaying the implementation date to October 1, 2012, and correspondingly reducing administration costs.

Although the *2012-13 Governor's Budget* proposed a 2 percent SOC for private insurance clients, the *2012-13 May Revision* does not propose any SOC for this group. All ARV drug companies have co-pay assistance programs for persons with private insurance with varying eligibility criteria and benefits. Imposing a SOC would facilitate the transition of these ADAP clients with private insurance to drug company co-pay assistance programs, which would result in the loss of rebate revenue and net savings. Since ADAP receives full rebate on partial pay claims for ADAP clients with private insurance, it is in state's best interest to retain as many private insurance clients in ADAP as possible. For example, if 50 percent of our private insurance clients leave ADAP for co-pay assistance programs, ADAP would realize a net loss of $3 million in FY 2012-13 when accounting for the six-month rebate delay and a net loss of $15.43 million when not accounting for the six-month delay.

After making these adjustments, including a corresponding reduction in administration costs with the elimination of SOC for ADAP clients with private insurance, the FY 2012-13 net savings due to implementing a SOC are **$10.67 million**, which consists of $11.98 million in revenue, $256,087 in reduced drug expenditures, $201,770 in loss of rebate revenue, and $1.36 million in administrative costs (**Table 20**).

TABLE 20: SUMMARY SOC FISCAL PROJECTIONS, FY 2012-13.					
LINE ITEM	**ADAP**	**MEDI-CAL**	**PRIVATE INSURANCE**	**MEDICARE**	**TOTAL**
SOC Rate	**5 / 7 / 10%**	**5 / 7 / 10%**	**0%**	**5 / 7 / 10%**	**n/a**
Revenue	$10,212,191	$152,165	$0	$1,613,926	$11,978,282
Exp. Savings	$43,946	$17,307	$0	$194,834	$256,087
Rebate Loss	-$7,910	$0	$0	-$193,859	-$201,770
Admin	-$1,215,909	-$14,006	$0	-$131,197	-$1,361,112
TOTAL NET	**$9,032,318**	**$155,466**	**$0**	**$1,483,703**	**$10,671,487**

In the *2012-13 May Revision*, OA did not assume an accelerated movement of clients into LIHP due to institution of the expanded ADAP SOC because of the uncertainty surrounding LIHP implementation timing.

RMA 4. Increase Rebate Percentage

In the *2012-13 Governor's Budget*, OA used the most recent 12 quarters of rebate collections, FY 2007-08 Quarter 4 through FY 2010-11 Quarter 3, to calculate its rebate percentage. For the *2012-13 May Revision*, the 12 quarters were updated to include FY 2008-09 Quarter 1 through FY 2010-11 Quarter 4 and late payments received, which increased the overall rebate percentage **from 48 percent to 50 percent**.

RMA 5. Renegotiated Supplemental Rebate/Price Freeze Agreements

Since the overall rebate percentage will be increasing (to 50 percent, **RMA 4**), another adjustment was made to the final rebate calculation to reflect the additional rebate revenue due to the Patient Protection and Affordable Care Act and AIDS Crisis Task Force (ACTF) rebate negotiations in 2010. For FY 2010-11, the actual rebate percentage was 56 percent, which equates to a 6 percentage point adjustment factor. This additional 6 percentage points of rebate is accounted for in the FCS (**Table 23**, page 35), section *Adjustment to ADAP Revenue Projections*, line*: Renegotiated Supplemental Rebate/Price Freeze Agreement (**RMA 5**)*. For FY 2011-12, the additional rebate amount is $13,640,179 (estimated expenditures of $227,336,310 X 6 percent), and for FY 2012-13, the additional rebate amount is $32,064,383 (estimated expenditures of $534,406,376 X 6 percent), both which factor in actual rebate collected and/or six-month billing delay.

In December 2011, ACTF announced new supplemental rebate agreements with the ARV drug manufacturers. Most agreements start January 1, 2012 and continue through December 31, 2013 and should increase OA's rebate percentage over that received in FY 2010-11. However, due to the six-month delay in rebate collection, OA will not know the increased rebate percentage until the first quarter of FY 2012-13.

RMA 6. Reimbursement of Federal Funding through the Safety Net Care Pool for FY 2012-13.

In FYs 2010-11 and 2011-12, CDPH received one-time reimbursement funding from DHCS through the Safety Net Care Pool (SNCP) federal funds. In the *2012-13 Governor's Budget*, CDPH anticipated receiving $49,300,000 in FY 2012-13 from DHCS as a reimbursement. In the *2012-13 May Revision*, SNCP authority has been reduced to $17,150,000 in order to maximize the use of rebate funds. The *2012-13 May Revision* assumes that the $17.2 million reimbursement will be spent in the budget year.

RMA 7. Change in Methodology: Adjust Linear Regression Expenditure Methodology

In the *2012-13 Governor's Budget*, ADAP used monthly expenditures from August 2008 through July 2011 in the linear regression. In addition, ADAP made two pre-regression adjustments for the elimination of jails and reduced PBM transaction fees. ADAP discontinued service to jails in July 2010, and jail expenditures were removed from monthly expenditures from August 2008 through June 2010. Reduced PBM transaction fees were implemented in July 2011, and the lower fees were applied to monthly expenditures from August 2008 through June 2011. These pre-regression adjustments were performed prior to running the linear regression model and eliminated the need for a post-regression adjustment. If the pre-regression adjustments were not made, then the earlier data points in the model would include jail expenditures and higher transaction fees and latter data points would exclude jail expenditures and have lower transaction fees. By keeping all 36 data points similar with the assumptions in effect, they measure the same expenditures resulting in a reliable estimate without any potential bias.

For the *2012-2013 May Revision*, the following changes were made:

- For the 36-month regression model, monthly expenditures were updated from April 2009 through March 2012, with March 2012 expenditures estimated based on pro-rating the first seven-day invoice received in March 2012. ADAP receives weekly invoices from its PBM for each period from Monday through Sunday. The first invoice, March 1-4, 2012, included a weekend in which volume is typically less than the weekdays. To obtain a more representative daily average, ADAP computed the daily average from the second invoice, March 5-11, 2012. This daily average was multiplied by 20 for estimating the expenditures for the remaining days in March. The total estimated March expenditures were derived from summing the actual 11-day expenditures and the remaining 20-day estimate.
- In addition to the two pre-regression adjustments mentioned above, pre-regression adjustments were also made for three continuing assumptions in *2012-13 Governor's Budget* impacting expenditure estimates, as follows: 1) PBM Contract: Pharmacy Split Savings; 2) PBM Contract: Change in Pharmacy Reimbursement Rate; and 3) Legislation Affecting Medicare Part D True-Out-of-Pocket Costs (TrOOP). For these pre-regression assumptions, the estimated annual savings percentages were calculated for each FY in the model. Then the corresponding

data points in the FY were reduced by that percentage. For example, if the new split savings would have saved 1 percent in FY 2008-09, 2 percent in FY 2009-10, and 3 percent in FY 2010-11, then we would subtract 1 percent from monthly expenditures from April 2009 through June 2009 (FY 2008-09), 2 percent from the monthly expenditures from July 2009 through June 2010 (FY 2009-10) and 3 percent from monthly expenditures from July 2010 through June 2011 (FY 2010-11). No adjustments were needed for July 2011 through March 2012 (FY 2011-12) since the assumption was in effect. The same process was used for each pre-regression assumption. This is the best method for handling "mixed data" in the regression model, in which monthly expenditures would otherwise have 27 data points (75 percent) without the assumptions and the remaining 9 data points (25 percent) with the assumptions.

Continuing Assumptions

These items were included in *2012-13 Governor's Budget* as Major Assumptions. Fiscal estimates were impacted due to updated data; there were no changes made to the estimate methodology except as detailed below:

CA 1. Reduced PCIP Premiums
For methodology, see **RMA 2**, page 26.

CA 2. OA-PCIP/LIHP Issue: Reductions in OA-PCIP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision
For methodology, see **RMA 2**, page 26.

CA 3. OA-HIPP/LIHP Issue: Reductions in OA-HIPP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision
No change in methodology from the *2012-13 Governor's Budget*.

For OA-HIPP, the updated data for the unadjusted estimate included the estimated expenditures and clients from the linear regression model, actual FY 2010-11 rebate percentages instead of FY 2009-10 and average estimated annual premiums per client of $5,735 in FY 2011-12 instead of $3,981 in FY 2010-11. The LIHP ramp-up was applied for OA-HIPP client transition.

Compared to the *2012-13 Governor's Budget* net savings of $1,901,401 for FY 2011-12, OA now estimates a net savings of **$1,060,646** ($4.52 million in premiums, $5.66 million in reduced drug expenditures and $80,643 in loss of rebate revenue), which equates to a reduction in net savings of $840,755. In the tables below, total estimate = premiums + drug expenditures – rebate revenue.

However, for FY 2011-12, an adjustment was made for nine months of OA-HIPP data already built into or captured by the linear regression model (July through March). To estimate the three-month savings for the remainder of the FY (April

through June), we computed one-fourth (3 out of 12 months) of the totals for each issue. Thus, the final adjusted totals entered into FCS to represent the numbers for partial year savings not accounted for by the model. For example, the annual drug expenditure savings for the unadjusted estimate was $6,137,597, and the April through June savings for FCS was one-fourth or $1,534,399.

TABLE 21: SUMMARY OF OA-HIPP CHANGES, FY 2011-12

ISSUE	PREMIUMS	DRUG EXPEND$	REBATE REVENUE	TOTAL ESTIMATE	CLIENTS
Unadj. Estimate	$4,899,566	-$6,137,597	-$87,479	-$1,150,553	1,538
LIHP: CA 3	-$382,863	$479,605	$6,836	$89,907	-278
TOTAL	**$4,516,703**	**-$5,657,992**	**-$80,643**	**-$1,060,646**	**1,261**

Negative (-) expenditures and (-) net = expenditure reduction; and negative (-) revenue = rebate loss.

For FY 2012-13, the net savings of **$2,449,739** consists of $6.73 million in premiums, $9.44 million in reduced drug expenditures and $260,773 in loss of rebate revenue. This represents a reduction in net savings of $1,924,033 from the *2012-13 Governor's Budget* net savings of $4,373,772.

Unlike FY 2011-12, no adjustment was needed for FY 2012-13 because none of the months in FY 2012-13 were built into or captured by the linear regression model. The full-year savings would still be applicable for the FCS.

TABLE 22: SUMMARY OF OA-HIPP CHANGES, FY 2012-13

ISSUE	PREMIUMS	DRUG EXPEND$	REBATE REVENUE	TOTAL ESTIMATE	CLIENTS
Unadj. Estimate	$9,086,135	-$12,654,836	-$313,945	-$3,254,756	1,613
LIHP: CA 3	-$2,352,869	$3,211,058	$53,173	$805,016	-254
TOTAL	**$6,733,267**	**-$9,443,778**	**-$260,773**	**-$2,449,739**	**1,360**

Negative (-) expenditures and (-) net = expenditure reduction; and negative (-) revenue = rebate loss.

CA 4. OA-HIPP/Medi-Cal GF Issue: Using GF to Pay OA-HIPP Premiums and ADAP Drug Deductibles and Co-Pays for Clients Co-Enrolled in Medi-Cal with a SOC
No change in methodology from the *2012-13 Governor's Budget*.

FUND CONDITION STATEMENT

The FCS (see **Table 23**, next page) shows the status of the ADAP SF for FYs 2010-11, 2011-12, and 2012-13 and all the factors that impact the fund including revenues, expenditures, revenue collection rate, interest earned, and major assumptions.

For FY 2011-12, revenue estimates are based on actual rebates collected for the period January through June 2011 ($136,970,557) and actual expenditures for July through December 2011 ($227,336,310). A 50 percent (see **RMA 4**) rebate collection rate was applied to the actual expenditures to arrive at estimated revenue of $113,668,155. Actual rebates plus rebates estimated from actual expenditures resulted in projected revenue of $250,638,712. These revenues were adjusted to reflect the impact of current year assumptions yielding net revenue in the amount of $264,153,045. It is estimated that there will be an additional amount of $120,000 of revenue from interest.

For FY 2012-13, revenue estimates are based on updated projected expenditures for the period January through December 2012 ($534,406,376). A 50 percent rebate collection rate was applied to the estimated expenditures and adjustments were made for assumptions to arrive at the net revenue projection of $284,523,040. It is estimated that there will be an additional amount of $120,000 of revenue from interest.

Based on the revised linear regression and impact of assumptions, the revised FY 2011-12 total GF appropriation is $4,755,668, a $77,869,332 decrease from the Budget Act. The total GF appropriation for FY 2012-13 is $6,203,925, a decrease of $76,421,075 from the FY 2011-12 Budget Act and an increase of $1,448,257 from the revised FY 2011-12 appropriation.

MAY REVISION FUND CONDITION STATEMENT

Table 23: MAY REVISION FUND CONDITION STATEMENT				
	Special Fund 3080 AIDS Drug Assistance Program Rebate Fund	FY 2010-11 Actuals	FY 2011-12 Estimate	FY 2012-13 Estimate
1	BEGINNING BALANCE	11,309	57,874	32,125
2	Prior Year Adjustment	4,839	0	0
3	Adjusted Beginning Balance	16,148	57,874	32,125
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS			
5	Revenues			
6	150300 Income From Surplus Money Investments	140	120	120
7	161400 Miscellaneous Revenue	262,890	264,153	284,523
8	Total Revenues, Transfers, and Other Adjustments	263,030	264,273	284,643
9	Total Resources	279,178	322,147	316,768
10	EXPENDITURES AND EXPENDITURE ADJUSTMENTS			
11	Expenditures			
12	8880 FI$Cal	1	0	0
13	0840 State Controllers Office	56	33	2
14	4260 Department of Health Care Service (State Ops)	9	0	0
15	4265 Department of Public Health			
16	State Operations	1,073	981	912
17	ADAP Local Assistance	220,165	283,632	293,026
18	OA-PCIP, OA-HIPP, and Medicare Part D Local Assistance		5,376	7,730
19				
20	Total Expenditures and Expenditure Adjustments	221,304	290,022	301,670
21	**FUND BALANCE**	**57,874**	**32,125**	**15,098**

Row 6: Actuals for FY 2010-11, Estimated for FYs 2011-12 and 2012-13	140,426	120,000	120,000
Miscellaneous Revenue			
Actual Rebate resulting from Expenditures for Jan - Mar 2011		69,747,869	
Actual Rebate resulting from Expenditures for April - June 2011		67,222,688	
Estimated Rebates from Actual Expenditures from July-December 2011 ($227,336,310) at 50% avg rebate rate (RMA 4)		113,668,155	
Estimated Rebate from Estimated Unadjusted Expenditures for Jan - June 2012 ($257,454,488 x 50% avg rebate rate) (RMA 4)			128,727,244
Estimated Rebate from Estimated Unadjusted Expenditures for July - Dec 2012 ($276,951,888 x 50% avg rebate rate) (RMA 4)			138,475,944
Total Unadjusted Estimated FY 2011-12 Rebate Revenue		250,638,712	
Total Unadjusted Estimated FY 2012-13 Rebate Revenue			267,203,188
Adjustments to ADAP Revenue Projections:			
* LIHP: Impact of "Non-Legacy" Counties on ADAP (NMA 1)		0	-4,082,258
* LIHP: Impact of the Ten "Legacy" Counties on ADAP (RMA 1)		0	-9,199,072
OA-PCIP: If no other changes than updated data from *November Estimate*		-2,101,811	-7,591,875
OA-PCIP: Delayed implementation (RMA 2)		1,947,946	5,541,943
OA-PCIP: Reductions in Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (CA 2)		48,181	847,504
OA-HIPP:If no other changes than updated data from *November Estimate*		-21,870	-313,945
OA-HIPP: Reductions in Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (CA 3)		1,709	53,173
Renegotiated Supplemental Rebate/Price Freeze Agreement (RMA 5)		13,640,179	32,064,383
Row 7: ADAP Revenue Projections after Adjustments		264,153,045	284,523,040

*LIHP: Due to the delay in rebate collection, there will not be an impact in Revenue for FY 2011-12

	FY 2011-12 Estimate	FY 2012-13 Estimate
ADAP Expenditure Projection: FYs 2011-12 and 2012-13, Linear Regression (RMA 7)	**484,790,798**	**553,903,775**
Adjustments to ADAP Expenditure Projection:		
LIHP: Impact of "Non-Legacy" Counties on ADAP (NMA 1)	-695,548	-24,960,317
LIHP: Impact of the Ten "Legacy" LIHP counties on ADAP (RMA 1)	-1,987,497	-75,908,316
Less Client Cost Sharing (RMA 3)		-10,671,487
OA-PCIP: If no other changes than updated data from *November Estimate*	-11,082,363	-28,898,010
OA-PCIP: Delayed Implementation (RMA 2)	10,277,487	18,728,519
OA-PCIP: Reductions in Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (CA 2)	255,385	4,344,041
OA-HIPP: If no other changes than updated data from *November Estimate*	-1,534,399	-12,654,836
OA-HIPP: Reductions in Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (CA 3)	119,901	3,211,058
Subtotal: ADAP Expenditure Projection after Adjustments	**480,143,764**	**427,094,427**
Less: Federal Fund Appropriation (Earmark) (NMA 2, BY only)	-102,572,463	-105,179,281
Less: One-Time Federal Fund Increase RW Supplemental Awards (NMA 2, BY only) and Carryover (CY only)	-16,224,795	-8,425,807
Subtotal: Federal Fund	**-118,797,258**	**-113,605,088**
Less: Reimbursement funding through the Safety Net Care Pool (RMA 6)	**-74,064,000**	**-17,150,000**
Less: General Fund Appropriation for ADAP - per FY 2011-12 Budget Act	-82,625,000	-82,625,000
General Fund need for ADAP expenditures that are not allowable under RW	4,650,574	5,313,571
Less: Surplus funds after keeping funds for GF-only expenditures	-77,974,426	-77,311,429
Subtotal: General Fund Revised Appropriation for ADAP	**-4,650,574**	**-5,313,571**
Special Fund 3080 Need to meet Expenditure Projection for ADAP	**282,631,932**	**291,025,768**
Local Assistance Local Health Jurisdiction (LHJ)	1,000,000	2,000,000
Elimination of Tropism Assay testing	0	0
Row 17: Total Special Fund 3080 Need for ADAP	**283,631,932**	**293,025,768**

	FY 2011-12 Estimate	FY 2012-13 Estimate
OA-PCIP Expenditure Projection: Impact of OA-PCIP if no other changes than updated data from *November Estimate*	2,582,141	6,102,520
Adjustments to OA-PCIP Expenditure Projection:		
Delayed Implementation (RMA 2)	-2,203,729	-3,813,368
Reduced premiums (CA 1)	-60,603	-366,610
Reductions in caseload and savings due to LIHP and RW Payer of Last Resort Provision (CA 2)	-54,190	-736,951
Subtotal: OA-PCIP Expenditure Projection after Adjustments	**263,619**	**1,185,591**
OA-HIPP Expenditure Projection: Impact of OA-HIPP if no other changes than updated data from *November Estimate*	6,300,822	10,487,391
Adjustments to OA-HIPP Expenditure Projection:		
Reductions in caseload and premium savings due to LIHP and RW Payer of Last Resort Provision (CA 3)	-382,863	-2,352,869
Non-Add: Shift existing clients with Medi-Cal SOC from RW to GF (CA 4)	105,094	890,354
Subtotal: OA-HIPP Expenditure Projection after Adjustments	**5,917,959**	**8,134,522**
Total: Projected Expenditures for OA-PCIP and OA-HIPP	**6,181,578**	**9,320,113**
Less: Federal Fund Appropriation (RW Part B Base Funds)	-1,700,000	-1,700,000
General Fund need for OA-HIPP expenditures that are not allowable under RW	-105,094	-890,354
Special Fund 3080 Need to meet Expenditure Projection for OA-PCIP and OA-HIPP	**4,376,484**	**6,729,759**
Local Assistance Medicare Part D premiums	1,000,000	1,000,000
Row 18: Special Fund 3080 Need to meet Expenditure Projection for Insurance Programs	**5,376,484**	**7,729,759**
General Fund revised appropriation for ADAP	4,650,574	5,313,571
General Fund need for OA-HIPP expenditures that are not allowable under RW	105,094	890,354
Total General Fund Appropriation	**4,755,668**	**6,203,925**

***LIHP**: Due to the delay in rebate collection, there will not be an impact in Revenue for FY 2011-12

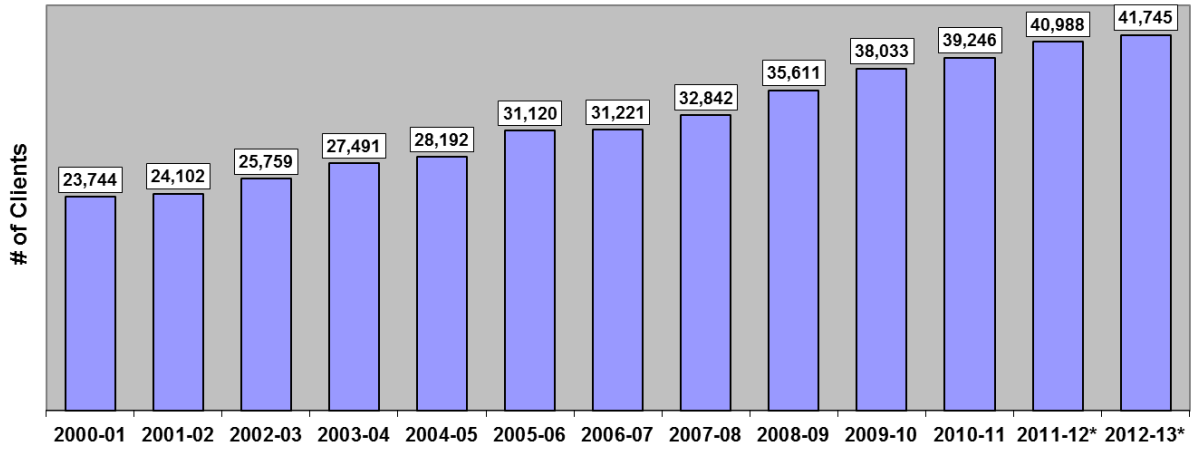
Note: NMA: New Major Assumption; **RMA**: Revised Major Assumption; **CA**: Continuing Assumption

4. HISTORICAL PROGRAM DATA AND TRENDS

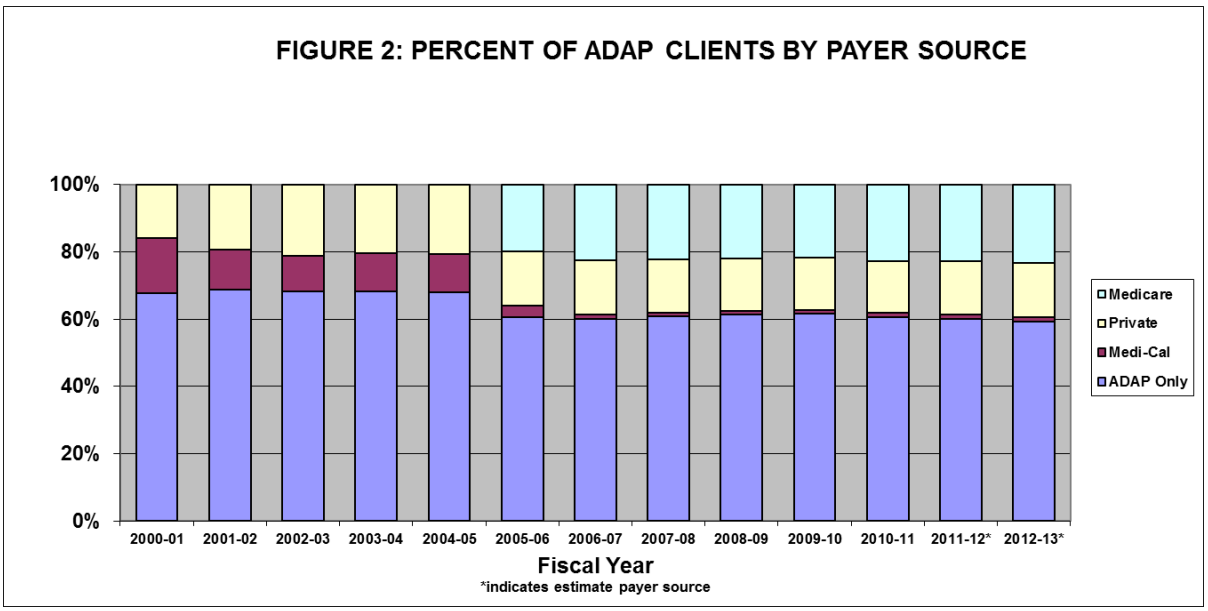
(*Data for FYs 2011-12 and 2012-13 are estimated, all other data are actuals)

For all figures and tables in Section 4, the data prior to FY 2011-12 is the observed historical data. To develop client and prescription estimates for FYs 2011-12 and 2012-13, we used a model similar to the 36-month regression model for expenditure estimates, where the 36 monthly data points were the number of clients and prescriptions. We then adjusted the estimates to take into account client, expenditure, and prescription adjustments due to LIHP (**NMA 1** and **RMA 1**) and OA-PCIP (**RMA 2** and **CA 2**).

FIGURE 1: ADAP CLIENT COUNT TREND



Note: ADAP does not realize a client reduction for FY 2012-13 because clients shifting out of ADAP due to LIHP during FY 2012-13 are still considered ADAP clients for FY 2012-13. They will no longer be ADAP clients with the start of FY 2013-14.

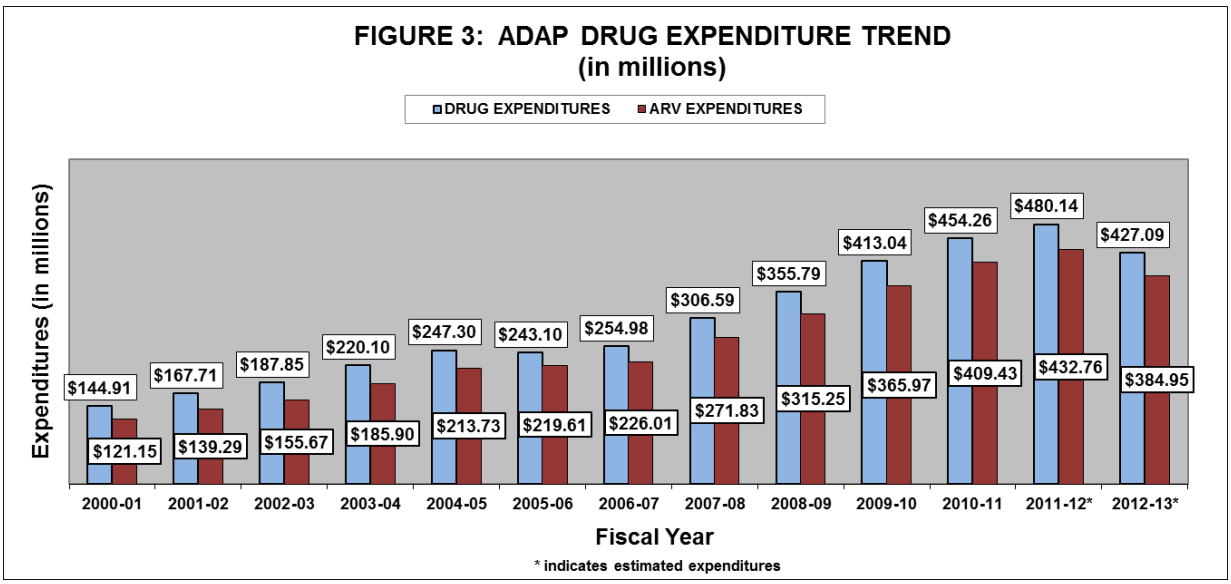


Note: The actual percentage of ADAP clients by payer source/coverage group in FY 2010-11 was applied to the estimated client counts in FYs 2011-12 and 2012-13 to estimate the percentage of clients by payer source.

TABLE 24: ESTIMATED ADAP CLIENTS BY COVERAGE GROUP

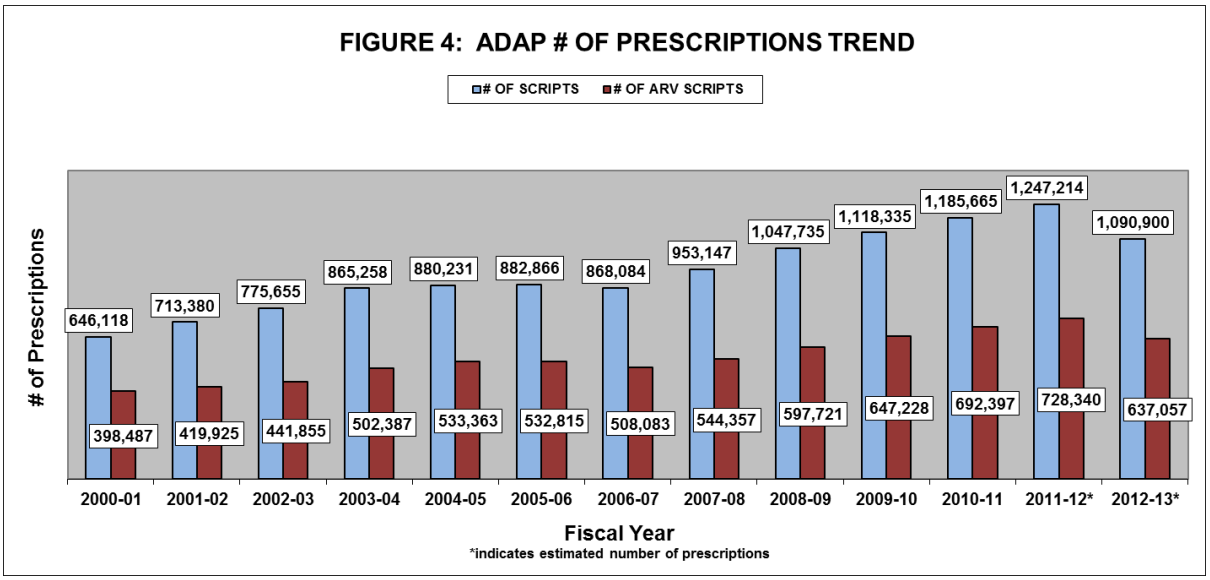
Coverage Group	FY 2011-12		FY 2012-13	
	Clients	Percent	Clients	Percent
ADAP	24,666	60.18%	24,776	59.35%
Medi-Cal	483	1.18%	506	1.21%
Private Insurance	6,531	15.93%	6,744	16.15%
Medicare	9,309	22.71%	9,720	23.28%
TOTALS	**40,988**	**100.00%**	**41,745**	**100.00%**

Note: The actual percentage of ADAP clients by payer source/coverage group in FY 2010-11 was applied to the estimated client counts in FYs 2011-12 and 2012-13 to estimate the percentage of clients by payer source.



Notes: The reduction in drug expenditures for FY 2012-13 is a reflection of savings due to LIHP and OA-PCIP. Drug expenditures do not include annual administrative support for local health jurisdictions or Medicare Part D, OA-HIPP, or OA-PCIP premium payments. For these costs see **Table 23**, page 35.

For ARV expenditures, we used the percentage of ARV expenditures to total expenditures in FY 2010-11 and applied this percentage to the estimated total drug expenditures in FYs 2011-12 and 2012-13 to estimate the amount of ARV expenditures for each year.



Note: The reduction in number of prescriptions for 2012-13 is a reflection of clients transitioning to LIHP. For the number of ARV prescriptions, we used the percentage of ARV prescriptions without jail prescriptions in FY 2010-11 and applied it to the estimated drug prescriptions in FYs 2011-12 and 2012-13 to estimate the number of ARV prescriptions.

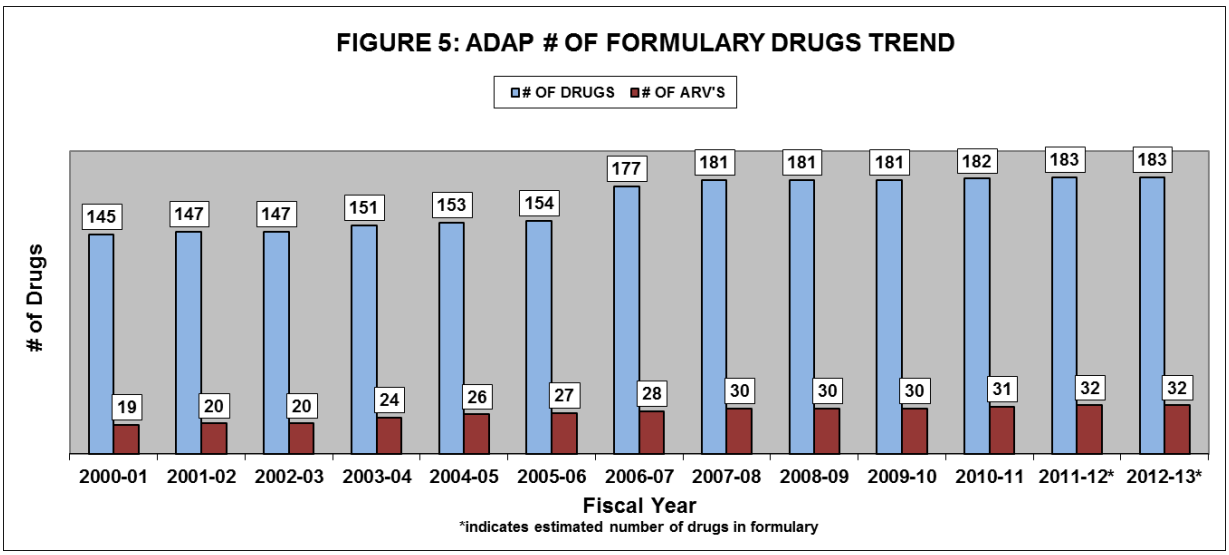


FIGURE 5: ADAP # OF FORMULARY DRUGS TREND
OF DRUGS
OF ARV'S
of Drugs
145
147
147
151
153
154
177
181
181
181
182
183
183
19
20
20
24
26
27
28
30
30
30
31
32
32
2000-01
2001-02
2002-03
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12*
2012-13*
Fiscal Year
*indicates estimated number of drugs in formulary

APPENDIX A: EXPENDITURE AND REVENUE ESTIMATE METHODS
Updated Expenditure Estimate for FYs 2011-12 and 2012-13

TABLE 25: LINEAR REGRESSION MODEL FOR MAY REVISION FOR FY 2011-12 COMPARED TO *2012-13 GOVERNOR'S BUDGET* (Actual Data April 2009 through February 2012, Estimated for March 2012)

May Revision*	*Governor's Budget*	Change from Previous Est ($)	Change from Previous Est (%)
$484,790,798	$514,211,350	-$29,420,552	-5.72%
*May Revision includes 3 additional pre-regression adjustments (**RMA 7**).			

TABLE 26: LINEAR REGRESSION MODEL FOR MAY REVISION FOR FY 2012-13 COMPARED TO *2012-13 GOVERNOR'S BUDGET* (Actual Data April 2009 through February 2012, Estimated for March 2012)

May Revision*	*Governor's Budget*	Change from Previous Est ($)	Change from Previous Est (%)
$553,903,775	$579,199,067	-$25,295,292	-4.37%
*May Revision includes 3 additional pre-regression adjustments (**RMA 7**).			

Linear Regression Model – Expenditure Estimates

The linear regression methodology is similar to the method used to estimate expenditures for FYs 2010-11 and 2011-12 in the *2012-13 May Revision* with three changes: 1) we used the updated range of actual expenditures, from April 2009 through February 2012; 2) we estimated March 2012 expenditures by: a) taking the invoiced expenditures for the first 11 days of March; b) calculating the daily expenditure rate for the seven-day invoice; and c) applying that daily expenditure rate to the remaining 20 days in the month; and 3) pre-regression adjustments were made for split savings, reimbursement rate and ADAP counting towards TrOOP (**RMA 7**). Using a more recent set of actual expenditure data to predict future expenditures allowed us to "fine tune" our previous estimates. Actual expenditures were lower than the estimated values previously predicted by the regression model used for FY 2011-12 in the *2012-13 Governor's Budget*, which resulted in the lower expenditure estimate FY 2011-12 as noted in **Table 25**.

Figure 6, page 43, shows ADAP historic expenditures by month. The regression line (red) represents the best fitting straight line for estimating the expenditures:

- During normal growth periods, a linear regression model should accurately predict expenditures (the red regression line goes straight through the data points).
- During low growth periods, a linear regression model would overestimate expenditures (the red regression line goes over the data points).

During high growth periods, a linear regression model using the point estimate would underestimate expenditures (the red regression line goes under the data points). Thus,

given the recent relatively high growth expenditure period beginning in FY 2007-08, and the desire not to underestimate the need for ADAP to utilize the ADAP SF to address increasing expenditures, we continue to use the upper bound of the 95 percent confidence interval around the point estimate for our regression estimates. This is the same strategy used during the previous estimate development.

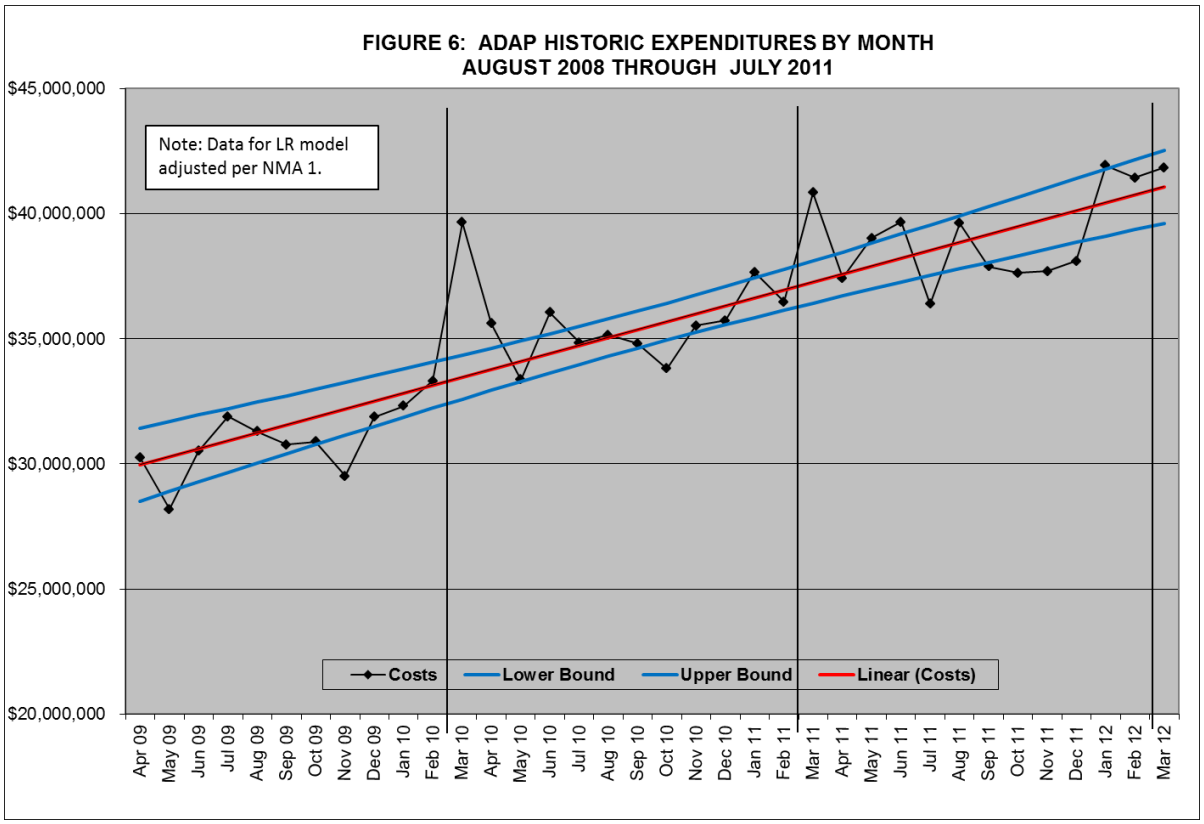


Table 27 displays historic drug expenditures by FY, annual change, and percent change.

TABLE 27: ADAP HISTORIC AND PROJECTED DRUG EXPENDITURES
(*Data for FY 2011-12 and FY 2012-13 are projected, all other data are actuals)

Fiscal Year	Expenditures	Annual Change in Expenditures	Pct Annual Change
1997-98	$86,674,336	N/A	N/A
1998-99	$98,924,742	$12,250,405	14.13%
1999-00	$119,465,151	$20,540,409	20.76%
2000-01	$144,913,504	$25,448,353	21.30%
2001-02	$167,709,426	$22,795,922	15.73%
2002-03	$187,854,138	$20,144,712	12.01%
2003-04	$220,101,760	$32,247,622	17.17%
2004-05	$247,299,716	$27,197,956	12.36%
2005-06	$243,096,942	-$4,202,774	-1.70%
2006-07	$254,977,392	$11,880,450	4.89%
2007-08	$306,590,832	$51,613,440	20.24%
2008-09	$355,786,400	$49,195,569	16.05%
2009-10	$413,035,251	$57,248,851	16.09%
2010-11	$454,426,055	$41,390,804	10.02%
2011-12*	$480,143,764	$25,717,709	5.66%
2012-13*	$427,094,427	-$53,049,337	-11.05%
Total Average	**FY 97-98 to 12-13**	**$22,694,673**	**11.58%**

Note: Drug costs include administrative costs at the pharmacy and PBM level. Drug costs do not include annual administrative support for local health jurisdictions or Medicare Part D, OA-HIPP, or OA-PCIP premium payments. For these costs see FCS (**Table 23**, page 35).

Notes: In FY 2005-06, ADAP expenditures decreased for the first time due to the enrollment of ADAP clients in Medicare Part D starting in January 2006. This also resulted in a lower than average increase in expenditures in FY 2006-07. The annual percentage increase in expenditures has decreased in FYs 2010-11 and 2011-12 because of the elimination of jail clients and the changes to TrOOP in FY 2010-11. Additionally, the 5.66 percent increase in expenditures projected for FY 2011-12 is less than the average annual increase due to the implementation of LIHP. Since the majority of LIHP-eligible ADAP clients will have shifted over to LIHP in FY 2012-13, expenditures are projected to decrease -11.05 percent.

ADAP Rebate Revenue Estimate Method

To forecast future revenue, the rebate revenue estimate method applies the expected revenue collection rate to estimated or actual expenditures (whichever is more current). The revenue collection rate has been increased from 48 percent to 50 percent (see **RMA 4** on page 30). Estimated revenue for a given FY is based on drug expenditures during the last two quarters of the previous FY and the first two quarters of the current FY. This six-month delay is necessary to take into account the time required for billing the drug manufacturers and receipt of the rebate. Revenue projections are adjusted to reflect assumptions and other adjustments that can increase or decrease revenues.

Revenue estimates in the *2012-13 May Revision* for FY 2011-12 were developed using actual rebates collected for the period January through June 2011 ($136,970,557) and actual expenditures for July through December 2011 ($227,336,310). A 50 percent (see **RMA 4**) rebate collection rate was applied to the actual expenditures to arrive at estimated revenue of $113,668,155. Actual rebates plus rebates estimated from actual expenditures resulted in projected revenue of $250,638,712. The resulting estimated revenue was then adjusted due to the fiscal impact of the revised and continuing assumptions to arrive at $264,153,045.

Revenue estimates in the *2012-13 May Revision* for budget year were based on updated estimated expenditures for the period January through December 2012. A 50 percent rebate collection rate was applied to arrive at the revenue projection of $267,203,188 and adjusted for the new, revised, and continuing assumptions for a final revenue estimate of $284,523,040.

It should be noted that the revenue estimate method uses average expenditures for each six-month period and does not directly take into account the seasonal behavior of expenditures that historical data show. As noted in previous Estimates, historical data show that drug expenditures are lower in the first half of the FY (July through December) compared to the second half.

TABLE 28: HISTORIC ADAP REBATE REVENUE COLLECTION PERCENTS BY QUARTER

FY-QTR	$ Drugs Purchased	Received in Rebate $	Received / Purchased
2002-03-Q1	$46,263,616	$10,136,693	21.91%
2002-03-Q2	$46,714,748	$10,257,857	21.96%
2002-03-Q3	$47,028,955	$10,146,224	21.57%
2002-03-Q4	$47,846,818	$10,846,426	22.67%
2003-04-Q1	$51,607,688	$12,275,494	23.79%
2003-04-Q2	$51,732,389	$15,045,513	29.08%
2003-04-Q3	$56,857,403	$17,801,378	31.31%
2003-04-Q4	$59,904,280	$19,249,713	32.13%
2004-05-Q1	$61,533,761	$19,334,264	31.42%
2004-05-Q2	$60,894,584	$18,691,012	30.69%
2004-05-Q3	$61,680,181	$19,176,357	31.09%
2004-05-Q4	$63,191,190	$15,847,186	25.08%
2005-06-Q1	$63,433,758	$21,866,164	34.47%
2005-06-Q2	$62,536,173	$20,612,704	32.96%
2005-06-Q3	$58,562,814	$26,768,577	45.71%
2005-06-Q4	$58,564,197	$25,095,840	42.85%
2006-07-Q1	$60,334,084	$24,791,394	41.09%
2006-07-Q2	$58,609,374	$24,489,071	41.78%
2006-07-Q3	$67,474,884	$32,724,197	48.50%
2006-07-Q4	$68,559,050	$31,734,710	46.29%
2007-08-Q1	$68,797,779	$33,524,051	48.73%
2007-08-Q2	$71,581,717	$35,262,749	49.26%
2007-08-Q3	$81,926,045	$44,200,318	53.95%
2007-08-Q4	$84,285,291	$39,834,969	47.26%
2008-09-Q1	$82,366,671	$36,272,892	44.04%
2008-09-Q2	$85,997,429	$38,043,925	44.24%
2008-09-Q3	$93,564,283	$46,300,283	49.48%
2008-09-Q4	$93,858,017	$40,827,251	43.50%
2009-10-Q1	$98,508,463	$44,718,090	45.40%
2009-10-Q2	$95,842,924	$44,131,629	46.05%
2009-10-Q3	$109,578,075	$55,921,631	51.03%
2009-10-Q4	$109,105,788	$55,287,500	50.67%
2010-11-Q1	$108,993,239	$56,542,420	51.88%
2010-11-Q2	$109,126,234	$60,631,590	55.56%
2010-11-Q3	$117,756,733	$69,747,869	59.23%
2010-11-Q4	$118,549,848	$67,222,688	56.70%

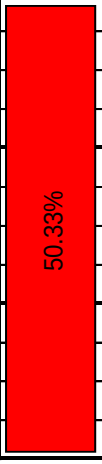


TABLE 29: COMPARISON OF REVENUE BETWEEN FY 2012-13 *May Revision* 2012-13 *Governor's Budget*						
UPDATED ESTIMATE FOR FY 2011-12						
Expenditure Period	**Available Data**	**May Revision**	**Available Data**	**Governor's Budget**	**Change ($)**	**Change (%)**
Jan - Mar 2011	Actual Rebates	$69,747,869	Actual Rebates	$59,349,638	$10,398,231	17.52%
Apr - Jun 2011	Actual Rebates	$67,222,688	Actual Expenditures @48%	$56,903,927	$10,318,761	18.13%
Jul- Dec 2011	Actual Expenditures @ 50%	$113,668,155	Estimated Expenditures@48%	$121,002,745	-$7,334,590	-6.06%
Subtotal Revenue Prior to Adjustments		$250,638,712		$237,256,311	$13,382,401	5.64%
Total Adjustments Due to Assumptions		13,514,334		$10,658,638	$2,855,696	26.79%
Subtotal Revenue After Adjustments		$264,153,045		$247,914,949	$16,238,096	6.55%
Interest		$120,000		$120,000	$0	0.00%
Total Revenue (see **Table 23**, Fund Condition Statement)		$264,273,045		$248,034,949	$16,238,096	6.55%

ESTIMATE FOR FY 2012-13						
Expenditure Period	**Available Data**	**May Revision**	**Available Data (Expenditure Period)**	**Governor's Budget**	**Change ($)**	**Change (%)**
Jan - Jun 2012	Estimated Expenditures @ 50%	$128,727,244	Estimate Expenditures @ 48%	$121,002,745	$7,724,499	6.38%
Jul - Dec 2012	Estimated Expenditures @ 50%	$138,475,944	Estimate Expenditures @ 48%	$136,295,469	$2,180,475	1.60%
Subtotal Revenue Prior to Adjustments		$267,203,188		$257,298,214	$9,904,974	3.85%
Total Adjustments Due to Assumptions		17,319,853		-$20,423,618	$37,743,471	-184.80%
Subtotal Revenue after Adjustments		$284,523,040		$236,874,597	$47,648,443	20.12%
Interest		$120,000		$120,000	$0	0.00%
Total Revenue (see **Table 23**, Fund Condition Statement)		$284,643,040		$236,994,597	$47,648,443	20.11%

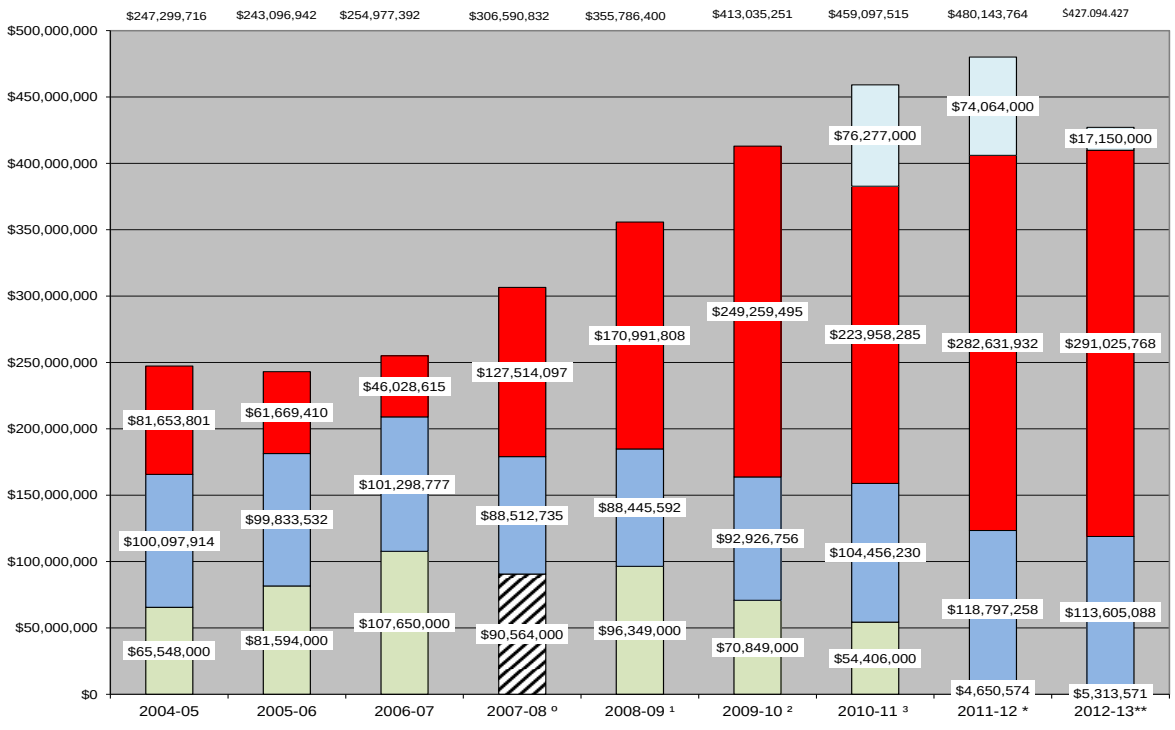
***Note:** When actual rebate data are not available, revenue projection methodology is based on actual expenditures (if available) or estimated expenditures. This method does not take into account the seasonal fluctuations between the first half of the FY (when expenditures are lowest) and the second half (when expenditures are highest).

APPENDIX B: FUND SOURCES

Payments of ADAP expenditures are made from four fund sources:

1. State GF appropriations.
2. Federal funding from HRSA through the RW Program. In addition, for FY 2011-12, OA received three one-time fund awards: RW Part B Supplemental Award of $1,376,784, RW Part B ADAP Supplemental Award of $8,028,154, and ADAP Emergency Relief Funding of $2,574,357. HRSA also approved CDPH's carry-over request for $4,245,500 of unspent funds from the 2010 RW Part B Grant for expenditures in ADAP during the 2011 RW grant period. For FY 2012-13, OA has received a one-time RW Part B ADAP Supplemental Award of $8,425,807.
3. Reimbursements from DHCS are one-time funding sources for FYs 2010-11, 2011-12, and 2012-13 as a result of additional federal resources available through the Safety Net Care Pool (SNCP).
4. ADAP SF consists of both mandatory and voluntary rebates from manufacturers with products on the ADAP formulary and interest payments from ADAP SF.

FIGURE 7: ADAP HISTORIC DRUG EXPENDITURES BY FUNDING SOURCE
(Data for FYs 2011-12 and 2012-13 are estimated, all other data actual)



º FY 2007-08: One time $7.285 M GF return; one time $9.8 M GF redirection to other OA programs for a total of $17.085 M backfilled with SF; permanent reduction of $10.530 M FF, backfilled with SF.
¹ FY 2008-09: Base $107.650 M GF allocation reduced by a permanent reduction of $7 M and $4 M redirection to other OA programs.
² FY 2009-10: Permanent reduction of $25.5 M GF, backfilled with $25 M SF (net -$500 K) to avoid a reduction in program services; including permanent reduction and redirection of previous FYs.
³ FY 2010-11: Reflects $11.5 M FF increase ($6.8 M FF in one time increase and $4.7 M FF permanent increase), $76.2M Reimbursement, $16.4 GF decrease, and $25.3M SF decrease from FY 2009-10 Budget Act.
* FY 2011-12: Reflects $14.3M FF increase, $49.8M GF decrease , $58.7M SF increase and $2.2M Reimbursement decrease.
**FY 2012-13: Reflects $5.2M FF decrease, $.663M GF increase, $8.4M SF increase, and $56.9M Reimbursement decrease.

General Fund

The GF appropriation is used for the purchase of prescription drugs for eligible clients. Due to the RW payer of last resort provision, GF is the only source of funding used by ADAP to cover the costs associated with clients eligible for other public assistance programs, including Medi-Cal. GF also pays the transaction fees invoiced by ADAP's PBM contractor for the administrative costs associated with managing prescription transactions that are ultimately identified as not eligible for ADAP payment.

The revised FY 2011-12 total GF appropriation is $4,755,668, a $77,869,332 decrease from the Budget Act. The total GF appropriation for FY 2012-13 is $6,203,925, a decrease of $76,421,075 from the FY 2011-12 Budget Act and an increase of $1,448,257 from the revised FY 2011-12 appropriation.

Federal Fund

Federal funding from the annual HRSA grant award through RW includes both "Base" funding and "ADAP Earmark" funding. The Base award from the grant provides funds for care and support programs within OA. The Part B Earmark award must be used for ADAP-related services only. The RW award is predicated upon the State of California meeting Maintenance of Effort (MOE) and match requirements. Non-compliance with these requirements will result in withholding a portion (match) or the entire (MOE) Part B federal grant award to California.

For FY 2011-12, ADAP received an increase in Earmark Federal funding of $4,940,484 for a total of $102,572,463 as well as three one-time fund awards: RW Part B Supplemental Award of $1,376,784, RW Part B ADAP Supplemental Award of $8,028,154, and ADAP Emergency Relief Funding of $2,574,357. HRSA also approved CDPH's carry-over request for $4,245,500 of unspent funds from the 2010 RW Part B Grant for expenditures in ADAP during the 2011 RW grant period for a total of $16,224,795. The total increase in federal funds for FY 2011-12 is $21,165,279.

The FY 2011-12 Enacted Budget included $3 million in federal authority in anticipation of these awards. Thus, OA submitted a Section 28 Letter requesting additional current year authority of $18,165,279. The increase in federal funds will be spent in the current year.

For FY 2012-13, ADAP received an additional increase of $2,606,818 in Earmark Federal funding for a total of $105,179,281 in ADAP Earmark local assistance funding. The NOA also included one-time funding for the 2012 RW Part B ADAP Supplemental Grant of $8,425,807.

Match

HRSA requires grantees to have HIV-related non-HRSA expenditures. California's 2011 HRSA match requirement for FY 2011-12 funding is $69,303,049 and 2012 HRSA

match requirement for FY 2012-13 funding is $70,606,470. OA will meet the match requirements by using GF expenditures from OA as well as the California Department of Corrections and Rehabilitation and the California HIV/AIDS Research Program.

MOE

HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior FY. California's MOE target, based on FY 2010-11 expenditures at the time of the Year 2012 HRSA grant application, is $502,476,676. Expenditures included in California's MOE calculations are not limited to OA programs and include HIV-related expenditures for all state agencies able to report GF expenditures specific to HIV-related activities such as care, treatment, prevention, and surveillance. Expenditures from SF may be used towards the MOE requirement.

Reimbursement

On February 1, 2010, Centers for Medicare and Medicaid Services approved DHCS's proposed amendment to the Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand DHCS's ability to claim additional State expenditures to utilize federal funding under SNCP. DHCS used certified public expenditures from various programs, including ADAP, to claim federal funds. CDPH will receive $76,064,000 of these funds from DHCS as a reimbursement for FY 2011-12 and will receive $17,150,000 for FY 2012-13, see **RMA 6** on page 31.

ADAP SF (3080)

The use of this fund is established under both state law and federal funding guidance. The ADAP SF was legislatively established in 2004 to support the provision of ADAP services. California Health and Safety (H&S) Code Section 120956, which established the ADAP SF, states in part:

"… (b) All rebates collected from drug manufacturers on drugs purchased through the ADAP implemented pursuant to this chapter and, not withstanding Section 16305.7 of the Government Code, interest earned on these moneys shall be deposited in the fund exclusively to cover costs related to the purchase of drugs and services provided through ADAP …"

ADAP receives both mandatory and voluntary supplemental rebates for drugs dispensed to ADAP clients; the original rebate law required by state (H&S Code Section 120956), subsequent federal (Medicaid) rebate law, and the latter nationally negotiated voluntary rebate established with individual drug manufacturers. Though these rebates constitute a significant part of the annual ADAP budget, the exact amount of rebate to be collected on an annual basis varies due to a number of factors, including quarterly changes in the federal calculation for the mandatory rebate due on the part of the manufacturer and the "voluntary" nature of the supplemental rebates.

Supplemental rebates (rebates beyond those required by the federal Medicaid rebate law) are negotiated on an ongoing basis by ACTF. ACTF is a rebate negotiating coalition of some of the largest ADAPs in the country (including California), working on behalf of all state ADAPs. ACTF enters into voluntary, confidential supplemental rebate agreements with drug manufacturers.

Though these agreements are entered into in good faith by both parties, there is no guaranteed continuation of the voluntary supplemental rebate. The agreements are generally entered into for an average term of one to two years but the drug manufacturer or the program can cancel the voluntary supplemental rebate agreement at any time with a 30-day written notice. Additionally, the rebate agreements are highly confidential and any unauthorized disclosure could invalidate the agreements, resulting in serious national implications for all state ADAPs.

Supplemental rebate agreements are in place for all ARVs on the ADAP formulary. This is significant, as ARV drugs' represent approximately 90 percent of all ADAP drug expenditures in FY 2010-11. Supplemental rebate agreement terms are generally based on either:

1. an additional rebate percentage; and/or
2) a price freeze.

Additional Rebate Percentage

The mandatory Medicaid 340B rebate is a percentage of the average manufacturers price (AMP), plus any penalties for price increases that exceed the inflation rate for the Consumer Price Index (CPI). Since AMP is confidential and not publicized, the resulting rebate amount is also unknown to ADAP. ACTF negotiations usually result in an additional voluntary, supplemental percentage of AMP. For example, if the current mandatory 340B rebate for brand drugs is 23 percent of AMP and ACTF has negotiated a supplemental rebate of 2 percent of AMP, then ADAP receives a total rebate of 25 percent of AMP.

"Price Freeze" Rebates

The "price freeze" option is another type of voluntary rebate offered by the manufacturer to compensate for commercial price increases. Currently, of the 32 available ARV medications on the ADAP formulary, ten (31 percent) are subject to a price freeze rebate. These ten drugs represented 52 percent of ADAP drug expenditures in FY 2010-11. If the manufacturers impose a price increase that exceeds CPI (inflation rate) while the price freeze is in effect, the program reimburses retail pharmacies at the higher price. Though this initially results in higher expenditures for the program, these price freeze agreements eventually offset the cost by increased rebates received and deposited in the SF.

ADAP Rebate Invoicing

ADAP invoices the manufacturers for drug rebates on a quarterly basis, consistent with both federal drug rebate law and drug industry standards. All ADAPs are required to invoice drug manufacturers within 90 days of the end of a given CY quarter (e.g., January through March, April through June, etc.) in compliance with federal requirements. ADAP mails drug rebate invoices approximately 60 days after the end of the quarter. For example, the January through March quarter invoice is sent out June 1. The time between the end of the billing quarter and the mailing of the invoice is necessary to generate and confirm the accuracy of the rebate invoices.

Timeframe for Receipt of Rebates

Federal HRSA guidance on ADAP rebate indicates that drug manufacturers are to pay rebate invoices from ADAP within 90 days of receipt. Federal Medicaid rebate law requires that drug manufacturers pay drug rebates within 30 days of receipt of a rebate invoice. Historically, the majority of drug manufacturers have paid rebates more closely to the Medicaid payment timeframe, usually within 30 to 60 days. However, receipt of rebate payments due for the first two quarters of CY 2011 indicate the manufacturers are now more closely following the HRSA timeframe of 90 days when processing ADAP rebate invoices.

Due to the above invoicing requirements and rebate payment timeframes, ADAP generally receives drug rebates six to nine months after program expenditures. Consequently, rebate due on expenditures in the second half of a given FY may not be received until the subsequent FY.

Funding from SF (3080) for Local Health Jurisdictions and Premium Payments

SF budget authority is requested as follows:

- $1 million in FY 2011-12 and $2 million in FY 2012-13 to local health jurisdictions to help offset the costs of ADAP enrollment and eligibility screening for clients at enrollment sites located throughout the state. Allocation is based on the number of ADAP clients enrolled during the prior CY. Funds may only be used for cost associated with the administration of ADAP;
- $1 million for the Medicare Part D Premium Payment Program. This program assists eligible clients in paying their Part D monthly premiums allowing them to receive the Part D benefit;
- $263,619 to cover premium payments for OA-PCIP in FY 2011-12; and
- $4,112,865 to cover premium payments for OA-HIPP in FY 2011-12.

APPENDIX C: POLICY ISSUES WITH POTENTIAL FUTURE FISCAL IMPACT

ADAP continues to monitor policy issues that have the potential to impact the fiscal condition of ADAP. These issues can occur within the state and federal arenas as well as the private sector. Because the future fiscal impact may be difficult to estimate, ADAP assesses the status of these issues on an ongoing basis. These issues are summarized below:

Future Fiscal Issues

1. Potential Payment of PCIP-Associated Medical Out-of-Pocket Costs

   OA-PCIP clients who are co-enrolled in ADAP will have their HIV-related prescription out-of-pocket costs covered through ADAP up to the $2,500 maximum. In the *2012-13 May Revision*), OA estimated that only 210 ADAP-only clients would enroll in OA-PCIP in FY 2012-13 mainly due to the high out-of-pocket medical costs. OA is exploring options to pay for OA-PCIP clients' out-of-pocket medical expenses. Should this appear to be feasible, OA will work in close collaboration with MRMIB to ensure that it is viable from their perspective. Administrative costs would also need to be estimated. Such a system would remove the disincentive for clients to enroll in PCIP and likely significantly increase enrollment, because most ADAP-only clients probably could not afford to pay for the $2,500 out-of-pocket maximum. Transitioning ADAP-only clients to PCIP not only provides clients with the benefit of full health coverage, rather than only HIV-related prescription drug coverage, but contributes to an overall reduction in state expenditures as well.

   Predicted fiscal impact: Increased OA-PCIP Savings (fiscal +).

2. One-Time Increase in Federal Funds: 2012 RW Part B Supplemental Application

   CDPH will apply for the 2012 RW Part B Supplemental Grant which CDPH will use for ADAP expenditures. This supplemental application addresses how states propose to eliminate, reduce, or avoid ADAP program restrictions including: waiting lists, capped enrollment, reduction to the ADAP formulary, reduction in the percentage of FPL requirement for ADAP eligibility, or other program restrictions on ADAP within the jurisdiction. HRSA anticipates awarding these funds by September 30, 2012.

   Predicted fiscal impact: Increased ADAP Resources (fiscal +).

3. Additional PBM Costs Due to Federally Mandated Bi-annual Client Re-certifications

   A federal (HRSA) mandate to conduct 6-month ADAP client re-certifications will result in increased costs for the ADAP Pharmacy Benefits Manager (PBM).

Currently, ADAP conducts client re-certifications on an annual basis. HRSA's mandate will require the PBM to closely coordinate with OA and local enrollment sites as they increase client re-certifications from once to twice per year. In order to implement bi-annual re-certifications, a number of augmentations, including the following, must be made to the PBM's scope of work:

- Ensure on-going responsiveness to ADAP enrollment worker, client and OA information requests including ensuring sufficient telephones, facsimile lines and staff.
- Modify and then maintain on an on-going basis the secure website and application notification and processing system including the ongoing notification of enrollment workers and clients of the upcoming biannual recertification.
- Develop biannual recertification processes and procedures and then process recertification applications, update the database and notify the enrollment worker upon recertification.

Discussions are currently underway to negotiate adjustments to the PBM contract but will not be completed in time for this May Revision document. The increased costs will be effective July 1, 2012 and will be reflected in the *November 2012 Estimate Package*.

Predicted fiscal impact: Increased ADAP Expenditures (fiscal -).

New Drugs that May be Available in the Next Three Years

Possible approval in late 2012 or early 2013

Combination elvitegravir, cobicistat, emtricitabine, and tenofovir (Quad)

On March 9, 2012, the manufacturer announced full results of the second pivotal Phase III study of the investigational fixed-dose, single-tablet "Quad" (four drugs) regimen of elvitegravir, cobicistat, emtricitabine, and tenofovir. The study found the Quad met its objective of non-inferiority at week 48 as compared to protease-based ARV regimen in treatment-naïve patients. The manufacturer also announced its intention to file for U.S. Food and Drug Administration (FDA) approval in the second quarter of 2012. ADAP will monitor for filing of the New Drug Application, Antiviral Drug Advisory Committee scheduling, and potential FDA approval. It typically takes approximately six months from filing to approval for ARVs. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

Elvitegravir

Elvitegravir is an investigational integrase inhibitor therapy that is in Phase III clinical trials. If approved, elvitegravir will offer a once-daily dosing option for integrase

inhibitors, as compared to the currently available raltegravir, which requires dosing twice daily. Once FDA approved, there may be a shift from current raltegravir users to elvitegravir because of the reduced dosing requirement. In addition, patients may switch from once a day protease inhibitors (PI) and non-nucleoside reverse transcriptase inhibitors (NNRTI) once a daily integrase inhibitor is available. Assuming successful negotiations with the manufacturer by ACTF, it is anticipated the net cost of elvitegravir (after rebates) will be comparable to raltegravir, which is comparable to once daily PIs and NNRTIs. This drug is also being studied as part of the previously discussed "Quad" formulation's trials which are in Phase III. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

The manufacturer announced in February 2012 that it would file for FDA approval of elvitegravir some time after the Quad filing in the second quarter of 2012.

Cobicistat

Cobicistat is being developed both as a pharmacokinetic booster for the integrase inhibitor elvitegravir and as a booster for PIs. The Phase II study compared efficacy and safety of cobicistat (150 mg) with that of the existing booster ritonavir (100 mg daily). Participants are currently being sought for a Phase III clinical trial to further study cobicistat as a PI booster. This drug is also being studied as part of the previously discussed "Quad" formulation's trials which are in Phase III. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

The manufacturer announced in February 2012 that it would file for FDA approval of cobicistat some time after the Quad filing in the second quarter of 2012.

Dolutegravir

Dolutegravir, a second generation integrase inhibitor with activity against raltegravir resistant and elvitegravir-resistant HIV, is in Phase III clinical trials. In March 2012, the manufacturer released Phase III clinical trial results that indicate once-daily dosing, along with two non-nucleoside reverse transcriptase inhibitors, was associated with good treatment responses at 96 weeks. ADAP will continue to monitor the drug's development.

Apricitabine

Apricitabine, an investigational NRTI, originally had its development halted in May 2010 after the manufacturer failed to find a licensing partner. In March 2011, the manufacturer reached an agreement with FDA to receive credit for previous clinical trials and the drug company has indicated plans to move forward with Phase III trials. There is currently no listing for open apricitabine studies in the federal clinical trials database. ADAP will continue to monitor the drug's development.

APPENDIX D: CURRENT HIV/AIDS EPIDEMIOLOGY IN CALIFORNIA

HIV Prevalence

Prevalence reflects the number of people who are currently infected with HIV and thus who could qualify for ADAP currently or sometime in the future. California estimates that between 152,656 and 173,843 persons were living with HIV/AIDS in California at the end of 2011, as seen in **Table 30**, below. This estimate includes people who are HIV positive but are not yet diagnosed (approximately 20 percent) by applying a national estimate of those unaware of their infection status that was developed by the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report, (MMWR, June 3, 2011). Living HIV/AIDS cases are estimated to be 45.1 percent White, 18.3 percent African American, 31.5 percent Latino, 3.6 percent Asian/Pacific Islander, and 0.4 percent American Indian/Alaskan Native. Most (65.2 percent) of California's living HIV/AIDS cases are attributed to male-to-male sexual transmission, 7.9 percent to injection drug use, 9.3 percent to heterosexual transmission, and 8.0 percent to men who have sex with men who also inject drugs.

The number of living HIV/AIDS cases in the state is expected to grow by approximately 2 percent (with a range of 2,800–5,400) each year for the next two years and it is expected that this increasing trend will continue for the foreseeable future. This increase is attributed to stable incidence rates and longer survival of those infected, primarily due to the effectiveness and availability of treatment.

TABLE 30: ESTIMATED PERSONS LIVING WITH HIV IN CALIFORNIA, 2009-2013

Year	Estimated persons to be reported with HIV (not AIDS) and presumed living*		Persons reported with AIDS and presumed living		Estimated persons living with HIV or AIDS**	
	Low bound	High bound	Low bound	High bound	Low bound	High bound
2009	43,368	55,371	67,223	68,049	147,200	163,083
2010	43,875	57,269	69,036	70,204	149,886	168,506
2011	44,409	59,141	70,888	72,318	152,656	173,843
2012	44,956	60,998	72,761	74,412	155,472	179,135
2013	45,512	62,847	74,647	76,493	158,315	184,400

*Assumes names-based HIV reporting system (established April 2006) is mature and meets CDC completeness standards

**Includes persons unreported and/or persons unaware of their HIV infection

HIV Incidence

Incidence is a measure of new infections over a specified period of time (typically a year) and thus provides an indication of the future need for ADAP support. Most people get tested infrequently, so incidence estimates largely rely on modeling. California estimates 5,000–7,000 new HIV infections annually. This estimate was developed through:

- A series of "consensus conferences" convened in California in 2000 that developed population estimates of HIV incidence; and
- Downward adjustment of the "consensus conference" estimate based upon observed reported HIV cases in the code based HIV surveillance system; numbers observed to date in the names-based HIV surveillance system are consistent with this adjustment.

Recent advances have made estimation of HIV incidence possible using remnant blood samples from people found to be HIV antibody positive. In 2004, CDC began a national effort to measure incidence using state-of-the-art technology on these remnant samples. Results of this effort were first reported in the August 2008 issue of Journal of the American Medical Association[1] and MMWR,[2] and CDC has subsequently provided updated national incidence estimates through 2009.[3] California data have yet to be included in calculating national estimates because names-based HIV reporting was required to be in effect for all of 2006 for inclusion in the most recent CDC paper, and it did not start in California until April 2006. The 95 percent confidence interval for the 2008 and 2009 national estimates (41,800 to 53,800 new infections and 42,200 to 54,000 new infections, respectively) are consistent with the 5,000 to 7,000 range OA estimated for California in 2005, suggesting new HIV infections have been relatively steady in recent years.

California has implemented HIV Incidence Surveillance using the CDC-developed Serologic Testing Algorithm for Recent HIV Seroconversion methodology. The initial point estimate of California incidence for 2009 based on the data and methodology provided by CDC is slightly above 5,000 (and thus in the aforementioned range). Data from this system will be used to revise California incidence estimates in the coming years.

[1] Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300(5):520—9.
[2] Subpopulation Estimates from the HIV Incidence Surveillance System — United States, 2006. MMWR 2008;57(36):1073-1076.
[3] Prejean J, Song R, Hernandez A, Ziebell R, Green T, et al. (2011) Estimated HIV Incidence in the United States, 2006–2009. PLoS ONE 6(8): e17502. doi:10.1371/journal.pone.0017502.

APPENDIX E: SENSITIVITY ANALYSIS

FY 2011-12

ADAP conducted a sensitivity analysis exploring the impact on total expenditures by increasing and decreasing the number of clients and the expenditures per client ($/client). For this sensitivity analysis, we started with the estimated total drug expenditures for FY 2011-12 using the upper bound of the 95 percent confidence interval from the linear regression model and subtracted cost/savings for all assumptions impacting drug expenditures.

For these factors, clients and expenditures per client, we created scenarios ranging from negative 3 percent to positive 3 percent, in 1 percent intervals. Those scenarios labeled as "Hi" represent 3 percent, "Med" represent 2 percent, and "Lo" represents a 1 percent change. The left column in **Table 31** below lists the seven (including no change) scenarios for changes in $/client, starting with the best case scenario {3 percent decrease in $/client, Hi(-)} and finishing with the worst case scenario {3 percent increase in $/client, Hi(+)}. The seven scenarios for changes in client counts are listed across the table.

TABLE 31: SENSITIVITY ANALYSIS FOR FISCAL YEAR 2011-12 EXPENDITURES' ESTIMATE USING LINEAR REGRESSION MODEL

$ / Client Scenarios	Number of Client Scenarios						
	Hi (-) Cl	Med (-) Cl	Lo (-) Cl	Zero Change in Clients	Lo (+) Cl	Med (+) Cl	Hi (+) Cl
Hi (-): Best	$451,889,612	$456,526,926	$461,164,241	$465,801,555	$470,438,869	$475,076,183	$479,713,498
Med (-)	$456,526,926	$461,212,048	$465,897,170	$470,582,291	$475,267,413	$479,952,535	$484,637,656
Lo (-)	$461,164,241	$465,897,170	$470,630,099	$475,363,028	$480,095,957	$484,828,886	$489,561,815
Zero Change in $ / Client	**$465,801,555**	**$470,582,291**	**$475,363,028**	**$480,143,764**	**$484,924,500**	**$489,705,237**	**$494,485,973**
Lo (+)	$470,438,869	$475,267,413	$480,095,957	$484,924,500	$489,753,044	$494,581,588	$499,410,131
Med (+)	$475,076,183	$479,952,535	$484,828,886	$489,705,237	$494,581,588	$499,457,939	$504,334,290
Hi (+): Worst	$479,713,498	$484,637,656	$489,561,815	$494,485,973	$499,410,131	$504,334,290	$509,258,448

The center cell highlighted in light blue shows the revised estimated expenditures for FY 2011-12, using the 95 percent confidence interval from the linear regression model and adjusted for all assumptions. The best case scenario, which is a 3 percent decrease in $/client coupled with a 3 percent decrease in the number of clients, results in an estimate of $451.89 million (top left cell, light green). The worst case scenario, a 3 percent increase in $/client coupled with a 3 percent increase in number of clients, results in an estimate of $509.26 million (bottom right cell, red). The table provides a range of values to assist in projecting the total expenditures for FY 2011-12.

FY 2012-13

Below is the sensitivity analysis for FY 2012-13, using the same logic that was used for FY 2011-12. In this sensitivity analysis, ADAP adjusted for several assumptions that impacted ADAP's FY 2012-13 total expenditures and total client count. Similar to the FY 2011-12 sensitivity analysis, we started with the estimated total drug expenditures for FY 2012-13 using the upper bound of the 95 percent confidence interval from the linear regression model. Then we subtracted savings for all assumptions. The "baseline" or center cell, highlighted in light blue below, reflects all adjustments to the linear regression expenditure projection. **Table 32** provides a range of values to assist in projecting the total expenditures for FY 2012-13.

TABLE 32: SENSITIVITY ANALYSIS FOR FISCAL YEAR 2012-13 EXPENDITURES' ESTIMATE USING LINEAR REGRESSION MODEL

$ / Client Scenarios	Number of Client Scenarios						
	Hi (-) CI	Med (-) CI	Lo (-) CI	Zero Change in Clients	Lo (+) CI	Med (+) CI	Hi (+) CI
Hi (-): Best	$401,961,974	$406,086,928	$410,211,882	$414,336,836	$418,461,791	$422,586,745	$426,711,699
Med (-)	$406,086,928	$410,254,407	$414,421,887	$418,589,367	$422,756,846	$426,924,326	$431,091,805
Lo (-)	$410,211,882	$414,421,887	$418,631,892	$422,841,897	$427,051,902	$431,261,907	$435,471,911
Zero Change in $ / Client	**$414,336,836**	**$418,589,367**	**$422,841,897**	**$427,094,427**	**$431,346,957**	**$435,599,487**	**$439,852,018**
Lo (+)	$418,461,791	$422,756,846	$427,051,902	$431,346,957	$435,642,013	$439,937,068	$444,232,124
Med (+)	$422,586,745	$426,924,326	$431,261,907	$435,599,487	$439,937,068	$444,274,649	$448,612,230
Hi (+): Worst	$426,711,699	$431,091,805	$435,471,911	$439,852,018	$444,232,124	$448,612,230	$452,992,336